What role, if any, can companion animals play in recovery from serious mental health difficulties?

By

Vicki Ford

Submitted for the degree of Doctor of Psychology

(Clinical Psychology)

July 2012

Volume 1

Department of Psychology

School of Human Sciences

University of Surrey

Acknowledgements

I would like to thank everyone who has encouraged and supported me over the past three years. In particular I want to thank my clinical supervisors for their knowledge and time during each of my placements. I am also very grateful and would like to thank my clinical tutor, Dr Vikky Petch, and my research supervisor, Prof. Arlene Vetere, for all their help and encouragement. Thanks also to the other trainees of cohort 38, for all their mutual support, even at times when it seemed like we might never finish! Special thanks go to my car share friends – it really was a team effort!

Finally I would like to say a massive thank you to my husband, Rich, and to my family, including Heidi, Ivor and Hattie, for all their patience and understanding over the last three years.

Contents

Academic Dossier

URN 6111384

Literature Review

Is there evidence that mindfulness-based therapy can benefit everybody?

January 2010

Year One

Word count: 4979 words

Abstract

Mindfulness based therapy has become increasingly widespread in recent years. Mindfulness involves attending to the constant flow of thoughts, perceptions and feelings that are experienced without evaluating or deliberating over them. This positioned review summarises the theoretical background of mindfulness relevant to its application in adult mental health settings. The main challenges facing research are explored, along with empirical evidence on the effects of mindfulness therapy in the treatment of depression and anxiety. Based on current evidence, it is suggested that mindfulness may be considered as an effective treatment for depression and anxiety, although one in need of further study. Mindfulness has been consistently demonstrated to have positive effects, across individuals with a range of psychological distress, and this review considers whether mindfulness interventions offer sound, evidence-based practice for use in adult mental health services.

Mindfulness is 'the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment' (Kabat-Zinn, 2003). Mindfulness is a mode of consciousness, requiring the ability to be aware both of the current internal state and the surrounding external environment; as well as the ability to concentrate attention on this awareness (Brown & Ryan, 2003). It is important to highlight that mindfulness occurs spontaneously, with individuals differing in their predisposition to process their experience in a mindful way. A lack of mindfulness, referred to as 'mindlessness', promotes unhelpful thought patterns and thereby increases psychological distress (Kabat-Zinn, 2003). Considerable evidence exists that levels of mindfulness can be

increased through formal training, using meditation practices with or without a cognitive behaviour therapy component (e.g. Segal *et al.,* 2002); accordingly the benefits of mindfulness are considered as a promising clinical intervention.

Why mindfulness?

Mindfulness originated in the Far East, as a key foundation of Buddhist meditation, and is now in widespread use in mental health services offered across the Western world (Baer, 2003). Some such diverse applications include mindfulness: as a predictor of improved relationship satisfaction (Barnes *et al.*, 2007); to improve quality of life and reduce stress symptoms in cancer patients (Carlson *et al.*, 2003); to decrease risk of 'burn out' in healthcare professionals (Shapiro *et al.*, 2005); to improve pain tolerance (Kingston *et al.*, 2007) and in the treatment of eating disorders (Kristeller & Hallett, 1999).

In England, the National Institute for Health and Clinical Excellence (NICE) issues evidence-based guidance on the promotion of health, as well as the prevention and treatment of illness. NICE Clinical Guidelines recommend appropriate treatment and therapy approaches for a wide range of different conditions and healthcare professionals are expected to refer to them alongside their clinical expertise (NICE, 2009). Mindfulness-based cognitive therapy (MBCT) is recommended, for 'people who are currently well, but have experienced three or more previous episodes of depression.' However, there is no further recommendation of mindfulness-based therapy (MBT) in published guidance for the treatment of depression with a chronic physical health problem, anxiety or obsessive compulsive disorder (NICE, 2009). Increasingly, adult mental health providers across the NHS are offering

MBCT and other MBT groups to service users with a variety of psychological difficulties, seemingly without the endorsement of NICE guidance.

Why review the literature?

A number of reviews and systematic analyses of the mindfulness literature have been published in recent years (Baer, 2003; Bishop, 2002; Coelho *et al.*, 2007; Grossman *et al.*, 2004). However, evidence relating to the use of MBT and MBCT in treatment routinely offered to service users in adult mental health settings provided by the NHS has not been reviewed. For instance, the author is employed by an NHS Foundation Trust, working as part of a Primary Care Mental Health Team, based in the community, to offer psychological interventions to adults of working age. We routinely offer service users with a range of psychological difficulties, including depression and anxiety, attendance at our eight-week mindfulness group as part of their treatment. We frequently receive positive feedback from those attending the group; although to date the efficacy of mixed-diagnoses MBT groups, whilst finding some support in the literature (e.g. Baer, 2003), has not been validated by NICE guidance. In addition, concern has been raised that, in certain circumstances, MBT may actually be unhelpful (e.g. Teasdale *et al.*, 2003).

This review summarises recent literature on the application of mindfulness in the provision of adult mental health services; with particular reference to depression, including recurrent depression and that with a chronic physical health component, and anxiety. The author has focussed the review in this way so as to maximise its relevance to practicing mental health professionals. Firstly, key constructs of mindfulness will be defined, along with a description of theory relevant to its application in mental health settings. Secondly, some of the main challenges facing research in this field

will be explored. Finally, empirical evidence on the effects of mindfulness based therapy in the treatment of depression and anxiety is reviewed.

What is mindfulness?

As outlined above, mindfulness can be defined as focussing attention on what is being experienced at the present moment, as opposed to attending to thoughts and feelings about the past or future (Roemer & Orsillo, 2003). There is variation in definitions of mindfulness applied by authors in the literature; however there are also considerable similarities across these. Dimidjian and Linehan (2003) suggest this supports an 'overarching conceptualization' which highlights three components of mindfulness: observing and focusing awareness, describing and recording, and taking part. They argue that these three components should be carried out: nonjudgmentally, effectively and in the present. Experiencing thoughts, feelings and sensations in the present moment, enables the individual to formulate a more adaptive response to each situation, rather than applying a pre-determined response in all eventualities (Borkovec, 2002). Mindfulness enables individuals to see that the majority of their thoughts and feelings, both internal and external, are experienced momentarily and are not permanent fixtures of their psychological landscape as they may previously have believed (Baer, 2003).

The author believes this 'overarching conceptualisation' to be a constructive, albeit theoretically derived, definition of mindfulness, as other broader definitions and historical interpretations frequently include concepts such as self-compassion and wisdom, which are difficult to quantify as part of a research programme.

Literature search strategy

A search for the term "mindfulness" using online databases returned 1587 results. This list was refined by limiting results to the following criteria: "peer reviewed", "linked full text" and "references available". The remaining 474 results were sorted by "relevance" and the first 90 abstracts were reviewed by the author. Several further searches, using the term "mindfulness" and "depression" or "anxiety" or "pain" were refined and reviewed in the same way. Finally, the reference lists of relevant articles were searched manually for additional publications.

What are the challenges for mindfulness research?

Mindfulness is taught in a secular framework with the aim of maximising its accessibility to those who may be deterred by an apparently spiritual therapy (Baer, 2003). However, it is critical that the integrity of mindfulness is preserved; that the depth and detail of meditative practice, are not disregarded by Western practitioners (Kabat-Zinn, 2003). Teasdale *et al.* (2003), draw attention to its traditional application as one component in a broader intervention aimed at the identification and minimisation of distress. They emphasize that is intended to facilitate a deeper understanding of suffering, not a 'cure'. Furthermore, differences in interpretation have been identified between those practising mindfulness in the United States and those in Thailand; with no consistent baseline level of mindfulness recorded on measures of mindfulness in sample populations from the two countries (Christopher *et al.*, 2009), which may have implications for its secular delivery in clinical contexts.

Several authors (e.g. Segal *et al.*, 2002) argue that those providing mindfulness interventions cannot maximise their effectiveness without consistently practising mindfulness meditation themselves. However, given the current time and workload pressures on professionals in mental health services, how realistic is it to expect adherence to recognised protocols of meditating for 45 minutes, six days a week? Kabat-Zinn (2003) stresses that, without an established personal practice of mindfulness, instructors are not able to deliver training to participants with the necessary 'energy, authenticity or ultimate relevance' and that a fundamental principle of MBT is instructors should never ask more of participants than they are prepared to do themselves.

Research has consistently shown that recipients of MBT and MBCT who adhere to homework requirements, demonstrate greater improvements than those who do not. Carmody and Baer (2008) found that the amount of time participants in a Mindfulness-Based Stress Reduction (MBSR) programme spent on formal meditation exercises between sessions was a significant predictor of increased levels of mindfulness and accordingly improvements in depressive symptoms and general well-being.

There is some debate in the literature about the most appropriate means of determining an individual's levels of mindfulness. Davidson *et al.* (2004) advocated the use of neural imagining studies of brain activity to distinguish differences in patterns of neural processing of negative emotions in individuals following training in meditation techniques. Brown and Ryan (2003) developed and trialled the Mindful Attention Awareness Scale (MAAS) with the intention of measuring a specific mode of consciousness that differentiates mindful individuals from others, demonstrating their greater level of self-awareness. Since its inception, the MAAS has been widely used and has been found to correlate with other measures of self-awareness and psychological well-being (Baer *et al.*, 2006).

Inclusion criteria

Studies were reviewed if they specifically addressed the use of mindfulness techniques to ameliorate symptoms of depression, including recurrent depression and that occurring with a chronic physical health difficulty (excluding a diagnosis of cancer), and anxiety in an adult population. Studies where mindfulness was not the main focus of a treatment programme were excluded.

Is there any evidence MBT is beneficial in the treatment of depression?

It is suggested that those who have recovered from severe depression are at increased vulnerability to relapse, as even mildly negative thinking can trigger a pattern of rumination and an overwhelming feeling of hopelessness, which may then escalate into another depressive episode (Teasdale *et al.*, 2000). It is hypothesised that the likelihood of recurrence can be decreased by educating individuals to have a greater awareness of any negative thoughts or feelings they may be experiencing and then to avoid inadvertently dwelling on them, thereby preventing any initial negative thoughts from influencing their subsequent feelings and behaviour (Nolen-Hoeksema; as cited in Teasdale *et al.* (2000).

Teasdale *et al.* (2000), in the absence of psychological interventions for currently well individuals to prevent recurrence of depression, developed a protocol for a new group therapy treatment, MBCT. MBCT differs from traditional cognitive behaviour therapy in that it does not focus on challenging

the content of negative thoughts, but rather on promoting awareness and changing the individual's relationship to them. In a pioneering trial they recruited adults who met standardised diagnostic criteria for recurrent major depression (145 participants) at three different sites and randomised them to a treatment as usual (TAU) group or a MBCT group plus TAU. They found that for participants with a history of three or more episodes of depression, receiving at least half the MBCT treatment, almost halved relapse rates over the follow-up period (37 percent of individuals relapsed in the MBCT group versus 66 percent of individuals in the TAU group). However, no statistically significant differences emerged between the two groups for participants with two or fewer episodes of depression. The strengths of this study are the large sample size and multi-centre design, utilising two populations in the United Kingdom (rural north Wales and the city of Cambridge) and one in Canada (metropolitan area of Toronto). The randomised distribution of participants to treatment groups by an allocator independent of the study team along with the fact that the researchers monitoring participants were 'blind' to which experimental group participants belonged to lend weight to the researchers' conclusion that the decrease in relapse rates was attributable to MBCT rather than experimenter bias. Although, no difference in numbers of participants being concurrently treated with anti-depressant medication emerged between the experimental and TAU groups, the study design does not control for non-specific therapeutic effects, such as the benefits of therapeutic attention and mutual support from attendance at a therapy group. A further possible confounding factor is that the instructors who delivered MBCT actually developed the treatment protocol, so it remains to be seen if these effects could be replicated by mental health practitioners who are not mindfulness experts as is more realistic in a clinical setting.

A subsequent study based in Cambridge comparing MBCT versus TAU for recently recovered adults (interestingly 76 percent of participants were female) provided further evidence that MBCT was more effective that TAU in decreasing relapse rates in participants with three or more previous

depressive episodes but that this effect was not observed for those participants with two previous episodes of depression (Ma & Teasdale, 2004). This finding remained significant, across both trials, even when baseline levels of depressive symptoms were taken into account in analyses, again adding to evidence for the effectiveness of MBCT. A potential weakness was the smaller sample size (n=75), although this may be offset as a 60 week timeframe (one treatment session per week for eight weeks and a 52 week follow-up period) was common to both. The one year follow-up period provides a realistic timeframe in which relapse is likely to occur (Keller *et al.*, as cited in Segal *et al.*, 2002) whilst minimising ethical issues that arise from delaying access to a potentially effective treatment to participants in the TAU group.

A major deficit in both these studies is the lack of comparison with either an active control group (for example a relaxation group) or a placebo condition. This type of 'pragmatic clinical trial', where a treatment is contrasted with TAU, does not provide data on the effect of a treatment, as any significant results could be due to participants' knowledge that they are taking part in a trial of a new treatment (Coelho *et al.*, 2007). Kuyken *et al.* (2008) attempted to address this issue by comparing MBCT with a maintenance dose of anti-depressant medication for individuals with recurrent depression. As earlier research relies heavily on the work of those responsible for developing the MBCT protocol, a key aspect of this study was the aim to determine whether similar results could be obtained by independent researchers. Importantly, residual depressive symptoms and quality of life indicators were also measured, in addition to relapse rates, giving a wider representation of effects. The large sample size (n=123 adults accessing primary care services across Devon) increases the validity of the trial, although, unlike earlier work, it does not have the further benefit of a range of sample populations such as for multi-centre trials. Furthermore, any additional benefits of the increased timeframe (15 months versus 12 months in previous trials) may be negated by the longer intervals between follow-up

assessments (three monthly versus bimonthly). They found that 46 percent of the MBCT group relapsed compared with 60 percent of the patients in the maintenance medication condition, suggesting that MBCT acts positively to maintain psychological well-being. Additionally, MBCT enabled participants to significantly reduce their reliance on anti-depressant medication with 75 percent of the MBCT group discontinuing medication altogether. Kuyken and his colleagues utilised a thorough and well designed trial protocol, taking into account and recording any potential differences between therapists administering MBCT, between the five MBCT groups that comprised the trial and also between participants as they were randomised to trial groups. They do not however address how or why mindfulness has a therapeutic effect, and they do not control for therapist attention or the benefits accrued from a mutually supportive group therapy environment.

Considering depression characterised by a chronic physical difficulty

The first MBSR programmes originated to treat chronic pain 30 years ago (Kabat-Zinn, (1982); as cited in Kabat-Zinn, 2003). Their main aim was to teach those suffering frequently from pain and illness how to meditate mindfully and then to apply this skill to their ongoing difficulties, by developing an awareness of their symptoms and facing these non-judgmentally and in the present (Kabat-Zinn, 2003). McCracken *et al.* (2007) hypothesised that those in chronic pain often develop a tendency to concentrate on their distressing physical symptoms and associated negative thoughts and emotions, leading to unhelpful patterns of avoidance behaviour that in turn limit their experience. Therefore, MBT endeavours not to reduce the pain felt but instead to alter how the pain is experienced and the influence pain exerts on functioning. Recent research aimed to explore the link between inherent levels of mindfulness and successful functioning in chronic pain patients, less than 10 percent of who were able to maintain full-time employment (McCracken *et al.,* 2007). They found that mindfulness was significantly

correlated with levels of functioning, whilst being unrelated to patient background, severity of pain and pain-related acceptance (taking part in activities despite the presence of pain and not attempting to control or avoid pain). A relatively large sample size (n=105) completed measures to determine levels of mindfulness, depression, acceptance of chronic pain, physiological anxiety related to pain, and daily functioning related to their levels of pain. The researchers give a clear justification for the inclusion of each measure therefore increasing confidence in their findings. Appropriate correlation analyses showed a significant relationship between a patient having a higher score on the MAAS and a lower reported level of pain-related distress and anxiety, depression and disability along with fewer detrimental effects on functioning and less reliance on medication to control pain. Regression analyses were then used to further demonstrate the direction of the correlation, increased mindfulness predicted improved functioning; although further experimental trials would be necessary to empirically confirm this result. Crucially, this work studied the impact of a predisposition to process one's experience mindfully and no intervention was directed at increasing participants' mindfulness skills. Therefore no exploration of the impact of mindfulness skills training on chronic pain patients was possible. A critical limitation of this work is an inability to generalise to wider populations as the trial sample was entirely comprised of patients referred to a tertiary care pain management clinic, 98 percent of whom reported their ethnicity as white.

Further work suggests that the losses associated with experiencing long term physical pain, such as the difficulties in maintaining employment, social activities and relationships may actually represent a grieving process rather than depression (Sagula & Rice, 2004). They conducted a trial in the United States which compared 39 patients attending a pain clinic who received an eight week mindfulness meditation programme with 18 patients on the waiting list. Significant differences emerged between the two groups on the initial stages of grief, with the treatment group proceeding more rapidly

through the grief cycle and experiencing a reduction in depression and state anxiety. However, no significant differences were seen on measures of adjustment to the latter stages of grieving or on trait anxiety. This work was novel in its application of mindfulness techniques to the grieving process and also added to earlier evidence that increases in mindfulness appear to mediate reductions in state anxiety (Kabat-Zinn (1985) as cited in Sagula & Rice, 2004). However the trial lost internal validity through the use of a wait-list comparison group (as opposed to random allocation of participants to a control group) therefore although the groups did not appear to differ significantly on baseline measures, this may compound factors mentioned earlier (such as therapist attention) or the groups may have differed significantly on other characteristics (such as intensity of pain or participant background). A further criticism is the reliance entirely on self-report measures, which can be influenced by participants' attitudes to the research project, thereby increasing potential for response bias. This risk may be further increased as firstly the researchers were not blind to participants' group and secondly one of the researchers actually delivered the mindfulness intervention.

Some of the most recently published work has explored how mindfulness may mediate this relationship between chronic pain and anxiety in southwest England (McCracken & Keogh, 2009). They proposed chronic pain clinic patients with greater fear of anxiety would also experience higher levels of emotional distress and less effective daily functioning, due to unsuccessful attempts to avoid the negative emotional and physiological impact of pain. They investigated whether a predisposition to higher levels of mindfulness decreased this emotional avoidance and so successfully reduced anxiety sensitivity. Correlation and regression analyses confirmed these hypotheses, with greater mindfulness along with acceptance decreasing the role of anxiety sensitivity in predicting reduced functioning from 21 percent of variance to approximately five percent of variance. However this study relies on a correlational design and therefore causation cannot be implied.

Additionally no mindfulness based treatment protocol was used to increase levels of mindfulness.

Considering the effect of mindfulness on anxiety generally

The rationale for mindfulness in the treatment of anxiety is based on the idea that paying attention non-judgmentally to only what is being experienced immediately may counteract effects of a 'fight or flight' reaction following activation of the sympathetic nervous system. It is hypothesised that practising mindfulness meditation when calm enables an individual to respond more adaptively rather than simply reacting in anxiety provoking situations (Kabat-Zinn (1991) as cited in Miller *et al.,* 1995).

Research into the use of MBT in the treatment of generalised anxiety disorder and panic disorder found that, following an eight-week programme, participants showed significant improvements in symptoms of anxiety (Kabat-Zinn *et al.*, (1992) as cited in Miller *et al.,* 1995). Additionally, these improvements were maintained at three months post-treatment and were independent of whether participants were concurrently taking medication prescribed for their anxiety. The researchers employed a comprehensive battery of both subjective and objective measures to determine the effects of the intervention on levels of anxiety, thereby increasing the validity of their work. However, the trial had a small sample size with results compiled from the 22 participants (out of the 24 initially recruited) who completed the programme based in Massachusetts, USA. Furthermore, the study did not utilise a randomised control group or compare the effects of MBT with other conventional treatments for anxiety.

Three years later, 18 of the original 22 participants were followed up to assess potential longevity of the therapeutic effects (Miller *et al.,* 1995). They found that over half of participants continued to practice mindfulness regularly and that just less than half of participants had received no further treatment for their anxiety following the MBT programme. Using appropriate analyses, a repeated measures analysis of variance (ANOVA), they demonstrated that the significant post-treatment reductions in anxiety were still present three years later, on every one of the outcome measures. Whilst the small sample size limits the generalizability of these remarkable findings, the researchers attempted to address this issue by comparing the sample group with a larger group who received the MBT intervention at the same time but were not subject to testing on the extensive battery of outcome measures. This larger group (n=39) competed just two anxiety measures but also demonstrated a significant reduction in anxiety symptoms at both post-treatment and at the three year follow-up. This makes it more probable that improvements were seen as a result of attending the MBT programme as opposed to participating in the research project. Critically, whilst the sample population were described as diagnostically 'heterogeneous' no mention was made of socio-economic, employment or ethnic background.

More recently, research in the Netherlands has attempted to determine the effectiveness of MBT in treating social phobia (Bögels *et al.*, 2006). As the thought patterns that maintain and perpetuate social phobia (hypervigilance to perceived social danger, avoidance of paying attention during social interactions and disproportionate self-focus) are all attention-based, they suggest that MBT could be beneficial in preventing individuals with social phobia from processing their experience in this way. In a small-scale study, they offered a programme comprised of MBT and task concentration training (where attention is redirected from self-focus to the present task) to ten individuals with a primary diagnosis of social phobia not currently being treated with medication. They found that, of the nine participants available at the end of treatment, all demonstrated a significant reduction in symptoms of

social phobia; with seven of the nine no longer receiving a diagnosis of social phobia at a follow-up two months post-treatment. This is the first published work to consider MBT as a treatment for social phobia and so the author considers it worthy of inclusion in the review despite it representing a pilot project as opposed to a clinical trial. Additionally, the researchers give a good description and clear explanation of the rationale for each treatment session in the programme and for the inclusion of each outcome measures used. However there are several potential issues with the methodology: a wait-list control was utilised as opposed to a randomised control group, several of the participants had comorbid psychological diagnoses including depression, the intervention was delivered to participants individually (as opposed to the traditional group format, thereby increasing the levels of therapist attention received) and as the treatment protocol was a hybrid of two interventions (mindfulness and task concentration training) it is difficult to determine their relative contributions to the positive outcomes recorded. However, the researchers did address the issue of comorbid depression and found that, using appropriate post hoc analysis, levels of depression did not change significantly throughout, therefore decreasing the likelihood that that the improvements seen were due to reductions in depression rather than social phobia.

A recent randomized trial in Canada (Koszyci *et al.*, 2007) compared the efficacy of MBSR in treating adults meeting diagnostic criteria for social anxiety disorder with that of group delivered cognitive behaviour therapy (GCBT). They found that although participants in both groups showed comparable improvements at the conclusion of treatment in relation to mood, quality of life and functioning; GCBT participants had significantly lower objective and subjective scores on social anxiety outcome measures. This well designed and thoroughly recorded study showed, using within-group analysis, participants in both interventions made clinically significant improvements on all outcome measures. MBSR and GCBT were both well accepted by participants with relatively low and comparable withdrawal rates

for both groups. Participants reported high levels of compliance with homework requirements, although it is important to consider they may exaggerate time spent on homework to appear to meet treatment protocols. Some limitations are: no control group to address potential effects of participation in research, randomisation procedures not documented, and participants recruited following response to a media advertisement and therefore not representative of the general clinical population as well as no mention of their socio-economic or ethnic backgrounds. A further issue is the delivery of GCBT by a mental health practitioner experienced in social anxiety compared with the MBSR intervention which was delivered by a 'lay person' experienced in mindfulness meditation but not social anxiety.

In conclusion

Having reviewed evidence for mindfulness in the treatment of depression and anxiety, the author believes it should be considered as an effective treatment, albeit one in need of further study. There are a number of well designed trials using at least one or preferably more of the benchmarks of quality research: randomisation of participants to conditions, control groups, large sample sizes, blinding of researchers, description of the treatment protocol including levels of adherence with it, and multi-centre populations. This lends weight to the author's conclusion that mindfulness appears to be beneficial in the treatment of a wider range of psychological difficulties than is conferred by NICE guidance. In the current financial climate, with increasing need for service providers to demonstrate good value for money; mindfulness based interventions, with a group format and longevity of therapeutic action, offer a cost effective treatment option.

In relation to the use of mixed-diagnosis MBT groups, there has been little in the way of formal evaluation. However where they have been found to be effective it is suggested this is the case as participants have a shared experience of psychological distress and make a commitment to the treatment programme; increasing their mindful awareness through formal meditation exercises and practice outside sessions. It would be constructive for these groups to be evaluated as a whole, whilst taking into account individual diagnoses in order to clarify the relative impact of mindfulness on specific conditions.

Research is necessary to substantiate results of observational and correlational studies of naturally occurring mindfulness and mindfulness interventions to date. In order to pre-empt a review of NICE guidance, randomised controlled trials with large sample populations will be required. Work is necessary to compare the benefits of integrated treatments such as MBCT with conventional CBT, to determine the relative contribution of mindfulness. Additionally diversity needs to be considered, with several papers not detailing participant background or characteristics and where these were reported a distinct lack of participant diversity emerged.

Finally, whilst the author considers it essential that mindfulness be made accessible to those who may be able to benefit, it is important that mindfulness is not taken out of context and treated as a 'cure', therefore ensuring it retains a fundamental non-striving acceptance of the present.

References

Baer, R.A. (2003). Mindfulness training as a clinical intervention: A conceptual and empirical review. [Electronic version]. *Clinical Psychology: Science and Practice, 10 (2)*, 125–143

Baer, R.A., Smith, G.T., Hopkins, J., Krietemeyer, J. & Toney, L. (2006). Using self-report assessment methods to explore facets of mindfulness. *Assessment, 13*, 27–45

Barnes, S., Brown, K.W., Krusemark, E., Campbell, W.K. & Rogge, R.D. (2007). The role of mindfulness in romantic relationship satisfaction and responses to relationship stress. [Electronic version]. *Journal of Marital and Family Therapy, 33,* 482–500

Bishop, S.R. (2002). What do we really know about mindfulness-based stress reduction. [Electronic version]. *Psychosomatic Medicine, 64*, 71–84

Bögels, S.M., Sijbers, G.F.V. & Voncken, M. (2006). Mindfulness and task concentration training for social phobia: A pilot study. [Electronic version]. *Journal of Cognitive Psychotherapy, 20 (1)*, 33–44

Borkovec, T.D. (2002). Life in the future versus life in the present. [Electronic version]. *Clinical Psychology: Science and Practice, 9*, 76–80

Brown, K.W. & Ryan, R.M. (2003). The benefits of being present: Mindfulness and its role in psychological well-being. [Electronic version] *Journal of Personality and Social Psychology, 84 (4)*, 822–848

Carmody, J. & Baer, R.A. (2008). Relationships between mindfulness practice and levels of mindfulness, medical and psychological symptoms and well-being in a mindfulness-based stress reduction program. [Electronic version]. *Journal of Behavioural Medicine, 31*, 23-33

Carson, L.E., Speca, M., Patel, K.D. & Goodey, E. (2003). Mindfulness-based stress reduction in relation to quality of life, mood, symptoms of stress, and immune parameters in breast and prostate cancer outpatients. [Electronic version]. *Psychosomatic Medicine, 65*, 571–581

Christopher, M.S., Charoensuk, S., Gilbert, B.D., Neary, T.J., Pearce, K.L. (2009). Mindfulness in Thailand and the United States: A case of apples versus oranges? [Electronic version]. *Journal of Clinical Psychology, 65 (6)*, 590–612

Coelho, H.F., Canter, P.H. & Ernst, E. (2007). Mindfulness-based cognitive therapy: Evaluating current evidence and informing future research. [Electronic version]. *Journal of Consulting and Clinical Psychology, 75 (6),* 1000-1005

Davidson, R.J., Kabat-Zinn, J., Schumacher, J., Rosenkranz, M., Muller, D., Santorelli, S.F., *et al.* (2003). Alterations in brain and immune function produced by mindfulness meditation. [Electronic version]. *Psychosomatic Medicine, 65 (4)*, 564–570

Dimidjian, S. & Linehan, M.M. (2003). Defining an agenda for future research on the clinical application of mindfulness practice. [Electronic version]. *Clinical Psychology: Science and Practice, 10 (2)*, 166–171

Grossman, P., Niemann, L., Schmidt, S. & Walach, H. (2004). Mindfulness-based stress reduction and health benefits : A meta-analysis. [Electronic version]. *Journal of Psychosomatic Research, 57*, 35–43

Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present, and future. [Electronic version]. *Clinical Psychology: Science and Practice, 10 (2)*, 144–156

Kingston, J., Chadwick, P., Meron, D. & Skinner, T.C. (2007). A pilot randomised control trial investigating the effect of mindfulness practice on pain tolerance, psychological well-being and physiological activity. [Electronic version]. *Journal of Psychosomatic Research, 62*, 297–300

Koszykci, D., Benger, M., Shlik, J. & Bradwejn, J. (2007). Randomized trial of a meditation-based stress reduction program and cognitive behaviour therapy in generalized social anxiety disorder. [Electronic version]. *Behaviour Research and Therapy, 45,* 2518–2526

Kristeller, J.L. & Hallett, C.B. (1999). An exploratory study of a meditation-based intervention for binge eating disorder. [Electronic version]. *Journal of Health and Psychology, 4*, 357–363

Kuyken, W., Byford, S., Taylor, R.S., Watkins, E., Holden, E., White, K. & *et al.*, (2008). Mindfulness-based cognitive therapy to prevent relapse in recurrent depression. [Electronic version]. *Journal of Consulting and Clinical Psychology, 76 (6),* 966–978

Ma, S.H. & Teasdale, J.D. (2004). Mindfulness-based cognitive therapy for depression: Replication and exploration of differential relapse prevention effects. [Electronic version]. *Journal of Consulting and Clinical Psychology, 72,* 31–40

McCracken, L.M. & Keogh, E. (2009). Acceptance, mindfulness and values-based action may counteract fear and avoidance of emotions in chronic pain: An analysis of anxiety sensitivity. [Electronic version]. *The Journal of Pain, 10 (4)*, 408–415

McCracken, L.M., Gauntlett-Gilbert, J. & Vowles, K.E. (2007). The role of mindfulness in a contextual cognitive-behavioural analysis of chronic pain-related suffering and disability. [Electronic version]. *Pain, 131*, 63–69

Miller, J.J., Fletcher, K. & Kabat-Zinn, J. (1995). Three-year follow-up and clinical implications of a mindfulness meditation-based stress reduction intervention in the treatment of anxiety disorders. [Electronic version]. *General Hospital Psychiatry, 17*, 192–200

National Institute for Health and Clinical Excellence (2009). *Depression in adults. Treatment and management* [Electronic version]. London, UK: National Institute for Health and Clinical Excellence.

Roemer, L. & Orsillo, S.M. (2003) Mindfulness: A promising intervention strategy in need of further study. [Electronic version]. *Clinical Psychology: Science and Practice, 10 (2)*, 172–178

Sagula, D. & Rice, K.G. (2004). The effectiveness of mindfulness training on the grieving process and emotional well-being of chronic pain patients. [Electronic version]. *Journal of Clinical Psychology in Medical Settings, 11 (4)*, 333–342

Segal, Z.V., Williams, J.M.G. & Teasdale, J.D. (2002). *Mindfulness-based cognitive therapy for depression.* New York: The Guildford Press.

Shapiro, S., Astin, J., Bishop, S. & Cordova, M. (2005). Mindfulness-based stress reduction for health care professionals: Results from a randomised trial. [Electronic version]. *International Journal of Stress Management, 12*, 164–176

Teasdale, J.D., Segal, Z.V. & Williams, J.M.G. (2003). Mindfulness training and problem formulation. [Electronic version]. *Clinical Psychology: Science and Practice, 10 (2)*, 157–160

Teasdale, J.D., Segal, Z.V. & Williams, J.M.G., Ridgeway, V., Soulsby, J. & Lau, M. (2000). Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. [Electronic version]. *Journal of Consulting and Clinical Psychology, 68,* 615–623

Appendix 1. – List of key terms used

CBT	Cognitive behavioural therapy
MBCT	Mindfulness-based cognitive therapy
MBT	Mindfulness-based therapy
MBSR	Mindfulness-based stress reduction
MAAS	Mindful Attention Awareness Scale
TAU	Treatment as usual
GCBT	Group delivered cognitive behavioural therapy

BLANK PAGE
IN
ORIGINAL

URN 6111384

Professional Issues Essay

Carers have needs too! Describe the implications of the move towards 'recovery-orientated practice' for carers of people experiencing mental health problems.

Year Two

January 2011

Word count: 5512 words

This essay is anonymised, some identifying details and all names have been changed to protect confidentiality.

"Concern for the carer's well-being is either marginal or non-existent....Carer well-being is considered important in so far as it relates to the maintenance of their role and the quality of care for the cared for person".

(Guberman *et al.*, 2003, pp.346)

Despite numerous government policies and initiatives over the last decade (such as Standard Six of the National Service Framework for Mental Health published in 1999), carers' needs are still frequently seen as secondary to those of the person they care for. As routine, long-term inpatient care for individuals with mental health difficulties has been acknowledged as inappropriate and accordingly phased out, the focus is now on caring for these individuals in the community (Askey *et al.*, 2009). In many instances, this has shifted the burden of care from mental health professionals to, often untrained, unpaid 'informal carers', who are for the majority, family members (Falloon *et al.*, 1993). In many circumstances informal carers act to bridge the gap between the inadequate service offered by 'care in the community' and the needs of their family members (Gray, 2009). Carers themselves describe the burden of caring for a person with mental health difficulties as a physical, psychological and financial one (Morgan *et al.*, 2010). Recent research suggests that there are 1.5 million informal carers supporting people with mental health difficulties in the UK today (Worthington & Rooney, 2010) and so it is the needs of these carers that will be considered here. As planned efficiency savings aiming to mitigate the current economic budget deficit take effect, this number can surely only be set to increase. Taken in combination with a greater emphasis on recovery for service users, the impact of current government economic policy on informal carers is uncertain.

What does recovery mean for service users and carers? Around twenty years ago the recovery movement emerged as a result of deinstitutionalisation of mental healthcare, legislation to counter

discrimination on the basis of disability (physical or otherwise) and a rise in consumer awareness. Recovery was redefined. Recovery no longer meant a return to "normal" or an absence of symptoms, instead "it is a way of living a satisfying, hopeful and contributing life even with limitations caused by the illness" (Anthony, 1993; as cited in Slade, 2009, pp.28). Taking a recovery approach requires a change in philosophy by mental health service providers. The emphasis of services and professionals is no longer 'making people better' but rather empowering service users to take control of their own journey towards personal recovery. Slade (2009) considers there to be four foundations necessary to support personal recovery from mental health problems: holding onto hope, developing self-identity, deriving meaning from life and taking responsibility for how you live your life. In summary, the service user is no longer a passive recipient of mental health services. It is the impact of this cultural shift on carers that I am interested in exploring here; as service providers move from an attitude of 'doing to' to an attitude of 'working alongside' service users.

Through considering the literature on recovery-based practice and carers' needs, I will relate relevant issues to my own experiences of being employed as a trainee clinical psychologist on placement within the National Health Service (NHS). Key issues emerging from a comprehensive search of the literature included difficulties in identifying who may be fulfilling a 'carer' role and whether they in fact consider themselves to be a carer; as well as the stigma they may face in caring for a person with mental health difficulties. Another important issue for carers working alongside mental health professionals is that of negotiating the balance between sharing information necessary to provide appropriate care whilst ensuring that service user confidentiality is maintained. Additionally, I will discuss the influence of recovery-orientated practice on any potential conflict between encouraging service users to take positive risks and safely managing possible crises. Finally future directions for research will be considered.

Identifying carers: "I'm not her carer, I'm her mum"

When a person receives a diagnosis of a mental health condition, relatives frequently find it difficult to accept both the changes in their family member and in their own role (Gray *et al.*, 2009). Research has shown that as carers adjust to these changes, they have clear needs of their own. For instance they need access to relevant information about any diagnosis, availability of support networks and an understanding of the likely pathways of care (e.g. Arksey, 2003). They can also struggle to differentiate between the responsibilities of being a partner or parent and those that come with being a carer (Repper *et al.*, 2006; as cited in Gray *et al.*, 2008). This can be because the label 'carer' implies a relationship based on dependency, as opposed to a relationship grounded in mutual respect (Guberman *et al.*, 2003). This failure to identify oneself as a carer may result in family members being denied access to sources of support offered by mental health services. They may also fail to take advantage of incentives or benefits aimed at supporting carers financially. Department of Health policy has recognised this issue and accordingly mental health professionals are expected to identify circumstances where an informal carer maybe supporting a service user and to ensure that they are offered a carer's assessment. Whilst this may seem straightforward, where service users are increasingly living in privately owned, community based accommodation, in practice it can be a challenge for mental health professionals to not only identify but to actually make contact with carers. This is further complicated by issues of consent to share information, which will be discussed in more detail later.

Adjusting: "This can't be happening to us"

A recent study of mental health professionals' views about emotions experienced by carers highlighted the importance of acknowledging the

potential for grief (Gray *et al.*, 2009). The researchers considered the perceptions of professionals from a range of disciplines and levels of seniority; however I found it helpful to bear in mind that they did not actually consult directly with carers. Taking account of this, I still believe that the circular model of grief conceptualised by Kubler-Ross (1969) can be useful in helping relatives to make sense of their own emotions where a close family member or friend has been diagnosed with a mental health condition. Denial of the diagnosis and feelings of despair or hopelessness are common, and it is this lack of hope that is contrary to the ideals of personal recovery. I came across this first hand in working with a service user, Amie, who was in her early twenties and had experienced three episodes of psychosis. At the time of the first episode, she had been studying for A-levels and it is possible that some of the increased stress associated with taking exams precipitated the episode. Since then she had started university and experienced a second episode of psychosis around the time of her first year exams. She returned to university at the start of her second year but had found it difficult to adjust and had then, in her words, "dropped out". As both her older sisters, as well as many of her peers, had successfully completed their degrees, this compounded her and her parents' feelings that she had failed in some way. Her parents were extremely supportive of her, although they struggled to adjust their expectations for her education, for instance by acknowledging that the intense stress associated with studying for exams may be unhelpful for Amie's mental health. This is where taking a recovery-based approach can benefit both service users and their carers; as I was able to emphasise to Amie and her parents that it is possible to live a positive and satisfying life even whilst experiencing another episode of psychosis remains a possibility. For example by considering more flexible ways of completing a degree or alternative interests of Amie's, such as horse riding, which may lead to other opportunities for employment. Thinking about the diagnosis of psychosis in this way helped them to adjust their expectations, whereas they had previously despaired about the future since their daughter had been diagnosed with as they described it, "a serious mental illness".

This 'sense of loss' following the diagnosis of a loved one with mental health difficulties was highlighted by Askey *et al.'s* (2009) research into carers' needs. He found that around the time of diagnosis, carers were frequently unsure about whom they could contact for help, and where they were able to approach mental health professionals, they often felt ignored or that staff members were too busy to talk to them. This research used focus groups to explore the perspectives of carers, service users and mental health professionals. I believe that approaching the question of carers' needs from the standpoints of different stakeholders, as in this case, has the potential to highlight discrepancies between the groups. Askey *et al.*'s (2009) finding that carers felt ignored is concerning as evidence shows that carers consistently regarded having a positive and collaborative relationship with mental health professionals as having benefits not only for themselves but also for the clinicians and the service users involved (Maskill *et al.,* 2010).

Taking a step back: "How can I be less involved?"

A recovery approach encourages individuals experiencing mental health difficulties to 'self-manage' their illness, for instance by taking responsibility for themselves and the treatment they receive (Slade, 2009). As a service user progresses along their journey towards recovery, they become increasingly independent and therefore less dependent on whoever may have been caring for them. This necessitates that the carer acknowledge change in their role. Both in the literature and across society much is made of the negative aspects of being a carer, however many of those acting as carers also report a positive impact of their role (e.g. Gray *et al.*, 2009). In one study carers described how looking after a relative with a diagnosis of bipolar disorder had increased their self-awareness along with developing their own resilience and resourcefulness (Maskill *et al.*, 2010).

Whilst on placement at a Primary Care Mental Health Team (PCMHT), I had the opportunity of working with a man in his mid-thirties, Fredrick, who had symptoms consistent with a diagnosis of Post Traumatic Stress Disorder (PTSD) following being the victim of an extremely violent, unprovoked attack. Prior to the attack Fredrick had been living independently, however he sustained such serious injuries that his father, Ralph, (who was retired), moved into his home to care for him. At the time I saw Fredrick his physical injuries had all but resolved, however his level of anxiety was disabling. He was terrified of leaving the house and insisted that his father accompany him everywhere. One aspect of our work together was to help Fredrick regain some of his independence, for instance by being able to visit the supermarket alone. However Ralph's reluctance to relinquish any part of his role as Fredrick's full time carer proved a difficult barrier to overcome in Fredrick's recovery. Ralph's need, as a father, to keep his son safe conflicted with Fredrick's need to regain his social identity as an independent adult. Through clinical supervision I was able to understand Ralph's anxiety in terms of his beliefs that as his son had been attacked once, a similarly violent attack could easily occur again. I believe that this is a clear example of a carer's need for support to enable them to feel confident in 'standing back' and allowing their loved one to take control of their own recovery journey.

Conversely there may also be times when a relative's needs are too great for a carer to manage and in these instances it is important that mental health professionals adequately support carers to withdraw from their responsibilities (Askey *et al.,* 2009). In these circumstances carers may need help to cope with feelings of guilt and professionals should ensure that carers are enabled to maintain contact with their relatives and to participate in decisions regarding their care, particularly if hospitalisation has been necessary.

Fighting stigma: "What's wrong with him?"

It is well established that perceiving oneself as stigmatised by others causes negative emotions, such as shame, and can lead to social isolation. There is also evidence that family members of people with mental health difficulties experience stigma and that this secondary stigma can increase carers' feelings of burden (Topor *et al.*, 2006) Recent research compared the effect of perceived stigma on family carers of an individual with a diagnosis of mental illness with family carers of an individual with an intellectual disability (Chou *et al.*, 2009). They found that perceived stigma had a stronger effect in decreasing quality of life in carers of individuals with mental illness. They attributed this finding to society's less sympathetic attitudes to those with mental health difficulties, believing the basis of these attitudes to be the perception that individuals or their families are somehow to blame for their difficulties. As this research was conducted in Taiwan, it would be interesting to compare these findings with a similar study utilising carers from other areas of the world. The aim of this being to determine whether this is a culturally specific finding or part of a wider phenomenon; regrettably I suspect the latter.

Another survey of carers found that many had limited opportunities for social activities or contact with friends, not due to the competing demands of their caring role as might be expected, but instead because they had chosen to withdraw from community activities due to the stigma associated with having a family member with mental health difficulties (Falloon *et al.,* 1993).

Taking a recovery approach can help to counter the stigma experienced by service users and their carers by encouraging us to think of mental health as a continuum on which we can all occupy differing positions over time. This acts to decrease the distinction between 'well' and 'unwell' or 'them' and 'us', which is the foundation of stigmatising attitudes. A recovery approach also emphasises the importance of service users establishing or reclaiming

valued social roles through their relationships with others (Slade, 2009). This works to decrease stigma by shifting the focus of a person's identity from their illness to their individual strengths and abilities. In researching this essay I found the words of one 'recovered' service user particularly exemplified this shift:

> "In the early 1980's I was diagnosed as schizophrenic....In 1993 I gave up being a schizophrenic and decided to be Ron Coleman. Giving up being a schizophrenic is not an easy thing to do....but more important, it means that you stop being a victim of your experience and start being the owner of your experience." (Coleman, 1999; as cited in Slade, 2009, pp.88)

Service users themselves frequently describe how they have been able to reclaim a sense of identity and purpose through contributing positively to others' lives (Davidson *et al.*, 2006a). I believe that seeing their 'mentally ill' family member contributing to their community in this way, would not only be a positive experience for carers, but could also act to counter society's negative attitudes towards those experiencing mental health difficulties.

Information sharing or preserving confidentiality:

"I'm just not kept in the loop".

There can be no doubt that, in order to care safely and effectively, carers need access to information. This means both general information about any diagnosis given or support they may be entitled to as well as specific information about medication or current challenges being experienced by the individual with mental health difficulties (Repper *et al.*, 2006). Without access to this information, carers are left feeling anxious, isolated and hopeless.

These negative emotions can lead the carer to resent the demands placed upon them by the service user and decrease their ability to cope with the rigours of their caring role (e.g. Arksey, 2003). However many mental health professionals regard this need for timely information sharing as conflicting with a service user's right to confidentiality. This potential for conflict to arise is acknowledged in Department of Health policy for carers (2006, pp.2; as cited in Gray *et al.*, 2008), which states that "confidentiality should not be accepted as an excuse for not listening to you". However a search of the literature clearly shows that carers still believe professionals are using 'confidentiality' as an excuse not to communicate effectively with them, with carers citing a lack of confidence in and support for information sharing at an organisational level as the reason for this. Recent research found that professionals saw service users' needs as their first priority and certainly as more important than their responsibility to ensure that carers were adequately informed (Gray *et al.*, 2008). In some cases, carers felt that not only did professionals see them as unimportant, but that some members of staff actually interpreted their attempts to obtain information as interfering or 'causing trouble'. The issue is further complicated by the fact that there may be times when the service user is too distressed or unwell to have capacity to give consent to share information with their carer (Arksey, 2003).

In direct contrast, mental health professionals working within a recovery framework could consider carers (along with service users) as 'experts by experience'. Regarding someone as an 'expert' in this way immediately engenders respect and suggests that their contribution is valuable, something that carers have long campaigned for (Morgan *et al.*, 2010). There is evidence that where carers have access to appropriate information to enable them to support their loved one effectively, they report fewer negative aspects of their caring role (Pinfold & Corry, 2003). Improving the communication of information in this way not only benefits carers and service users, but also the professionals themselves by offering opportunities to work together more creatively (Gray *et al.*, 2008).

Slade *et al.* (2007) explored service users', carers' and professionals' differing perspectives on information sharing and found that when asked "are there any occasions when information should be shared without service user consent?" only 65 percent of service users agreed that there were. This contrasted notably with the other stakeholders' responses, with 96 percent of carers and 97 percent of professionals stating that there were occasions when information should be shared without the service user's consent. There was also a significant discrepancy in responses when stakeholders were asked whether it was acceptable to break patient confidentiality if the service user lived with a carer. In this instance just under a quarter of both service users and professionals felt that this was acceptable compared with over half of the carers surveyed who agreed that it was appropriate to share information in these circumstances. These results are interesting as they highlight that carers can have very different needs from the individual they care for. Whilst this may seem obvious, in my experience of working in mental health services, professionals often use the shortened expression S.U.C. to refer to service user and carer involvement, although it is clear that grouping service users and carers together in this way ignores their vastly different needs.

By putting service users and their carers at the centre of planning and delivering interventions, a recovery-based approach offers a potential resolution to this common clinical dilemma facing professionals. For example service users should be offered the opportunity to record their wishes and to plan in advance for times when they may become too distressed by the challenges presented by their mental health difficulties to express their preferences adequately. These advance directives, which can also dictate how much information can be shared with whom, are now commonly part of the Care Programme Approach (CPA) system used by mental health teams to support service users and should be reviewed regularly.

However I believe that in practice, situations where a carer's desire for information is greater than the amount of information a service user is prepared to share are inevitable. Therefore, as a mental health practitioner it is essential to consider how best to support carers whilst maintaining the trust and confidence of a service user. Slade *et al.* (2007) make two useful suggestions, the first of which is to make a clear distinction between general information (developing the carer's existing knowledge and skills without revealing 'new' details of the service user's clinical presentation) and personal information which is specific to the service user's mental health condition. For example, I have found this distinction between general information, for which no consent is required and personal information, for which consent is necessary helpful in working with a young service user and his grandmother, who was acting as his carer. By sharing general information that complemented her existing knowledge of his difficulties, I was able to maintain a positive and honest line of communication to support her, whilst maintaining his right to confidentiality about our work together in therapy sessions. Finally, where service users do not give consent for information to be shared it can be helpful for carers to conceptualise this decision in terms of progress in their family member's recovery. This decision can be seen as a first step in taking responsibility for and regaining control over their treatment and their lives (Slade *et al.*, 2007).

Positive risk-taking or just taking risks?

Whilst I strongly believe that a recovery-orientated approach has much to offer carers as well as service users, there is real potential for conflict regarding the need for an individual to take risks along their recovery journey.

It seems that I am not alone, as when mental health professionals in the United States were asked to list their "top ten concerns about recovery in mental illness", number one was the idea that a recovery approach, specifically allowing individuals to make their own decisions, increases the risk of harm to the individual themselves or to others (Davidson *et al.*, 2006b). Therefore it is conceivable that carers may have similar reservations. They may have invested significant personal resources in caring for their loved one and may understandably be reluctant to see their relative or friend taking risks which they perceive may cause setbacks.

To address this issue mental health professionals need to work alongside carers and service users to help them to distinguish between 'harmful risk', actions that are illegal or are not socially acceptable, and 'positive risk taking', which can be thought of as risks or challenges that aid in personal development (Slade, 2009). Without taking positive risks it is impossible to grow, learn and in particular to develop skills in self-managing risk. This is not limited to individuals with mental health difficulties but is the process through which we all develop autonomy and establish our independence. Even with this distinction, there is still potential for conflict between professionals or carers and service users, as by definition taking a positive risk is still involves an element of risk and therefore a successful outcome cannot be guaranteed.

I encountered this dilemma whilst working with a female service user in her thirties, Polly, who had experienced severe social anxiety for the past ten years. Her anxiety was so overwhelming that she had resigned from six different jobs and was very socially isolated. At times of extreme distress Polly would self-harm (superficially cutting her arms and legs) as a coping strategy. Polly's husband of eight years, James, was very supportive of her and although he did not identify with the label 'carer', he fulfilled many of the functions of a carer role. In our psychology sessions, Polly and I worked to

define her recovery goals, one of which was to join a swimming club, as she had previously swum at a competitive level, which had given her a genuine sense of achievement. I was hopeful that this goal would help Polly to reclaim an identity outside her mental health difficulties, as well as offering positive opportunities for social interaction. However James was initially very reluctant for her to attend the swimming club as he feared that meeting new people would heighten her anxiety and could cause an increase in her self-harming behaviour. It was therefore important to consider steps that Polly could take to help her achieve her goal whilst being mindful that removing all 'risk' of failure was not necessarily beneficial to her recovery. I was able to emphasise this to James who was subsequently able to recognise that experiencing small setbacks could actually enable Polly to begin to rebuild her resilience and ability to cope with challenges.

This is an example of a carer being supported to manage positive risk taking, however carers can sometimes also need mental health professionals' support to manage harmful risks. For instance a recent study of over 100 carers who looked after a family member with psychosis, found that over three quarters had been the recipient of moderate to severe levels of aggressive behaviour in the past year (Loughland *et al.*, 2009). It is important to be mindful that the participants were carers for individuals with a diagnosis of psychosis and that this finding cannot therefore necessarily be generalised to carers of family members with other mental health difficulties. I believe that despite this limitation, their findings are still relevant as evidence from inpatient settings suggests that verbally aggressive behaviour directed towards staff can increase 'burnout' rates and decrease the staff team's morale (Bowers *et al.*, 2009). Worryingly though, a theme which persists throughout the literature is that carers do not feel that their concerns are 'taken seriously' by mental health professionals. In summary, whilst a recovery-orientated framework encourages professionals to focus on positive risk taking, we also have a responsibility to manage harmful risk and this

should, wherever practicable, be done in a collaborative and respectful manner with the service user's and carer's input as 'experts by experience'.

What do carers really need?

In researching and thinking about this essay, it has become apparent to me that carers' almost unanimously have a need to be listened to, included and treated with respect by professionals and service users alike. It seems to me that carers' needs have not changed so much as a result of mental health services moving towards recovery-orientated practice, but rather carers' hopes for their needs being met have been raised. The responsibility to ensure that these hopes become reality now lies with us, the mental health practitioners working alongside carers on a daily basis. It is about taking time to understand carer's individual needs, including how these may differ from the service user's needs, and to, wherever possible, address these needs. This may take the form of practical assistance such as providing better information or access to carer support groups, or it may simply involve acknowledging that carers are doing their best for their loved one, often in difficult situations. It is also about offering the best possible standards of care to individuals with mental health difficulties, as not to do so can surely only serve to increase the stress and frustration experienced by carers.

In researching the literature relating to carers' needs it became evident that carers are still, for the most part, being considered as a uniform group. I was encouraged to find that the majority of studies I have cited here acknowledged the potential for differences of opinion between different stakeholders in the mental health system, for instance: service users, carers, service providers and policy makers. However, I was left wondering why carers were so often regarded as having identical needs regardless of differences in their personal circumstances and those of the individual they

care for. For instance, the evidence base comparing the needs of carers who work outside the home with the needs of those whose caring role is a full time occupation was severely lacking. This was also true of research contrasting the needs of carers whose family member has an enduring mental health difficulty with the needs of carers where the mental health difficulty experienced may be of a more transient nature. These are just two of many possible comparisons that are surely relevant to a discussion of the impact of a recovery model on carers. Some of the studies I have referenced did make attempts to acknowledge the diversity of carers, however these primarily consisted of descriptions of carer characteristics (e.g. gender, ethnicity) and little effort was made to unpack the influence of these characteristics on their findings.

What does the future hold for carers? As the government's planned efficiency savings for the NHS begin to take effect, I envisage that carers may well be expected to contribute even further to meeting their relative or friend's care needs than they currently do. The efficiency savings could also present a challenge for community staff teams, as although they may be tasked with 'doing more with less', with 1.5 million informal carers in the UK they simply cannot afford to lose sight of carers' needs.

References

Arksey, H. (2003). Scoping the field: Services for carers of people with mental health problems. [Electronic version] *Health and Social Care in the Community,* 11, 335–344.

Askey, R., Holmshaw, J., Gamble, C. & Gray, R. (2009). What do carers of people with psychosis need from mental health services? Exploring the views of carers, service users and professionals. [Electronic version] *Journal of Family Therapy*, 31, 310–331.

Bowers, L., Allan, T., Simpson, A., Jones, J. & Whittington, R. (2009). Morale is high in acute inpatient psychiatry. [Electronic version] *Society for Psychiatry and Psychiatric Epidemiology,* 44, 39–46.

Chou, Y.C., Pu, C.Y., Lee, Y.C., Lin, L.C. & Kroger, T. (2009). Effect of perceived stigmatisation on the quality of life among ageing female family carers: A comparison of caters of adults with intellectual disability and carers of adults with mental illness. [Electronic version] *Journal of Intellectual Disability Research*, 53(7), 654–664.

Davidson, L., O'Connell, M., Tondora, J., Styron, T. & Kangas, K. (2006b). The top ten concerns about recovery encountered in mental health system transformation. [Electronic version] *Psychiatric Services*, 57(5), 640–645.

Davidson, L., Shahar, G., Staeheli Lawless, M., Sells, D. & Tondora, J. (2006a). Play, pleasure and other positive life events: "Non-specific" factors in recovery from mental illness? [Electronic version] *Psychiatry*, 69(2), 151–163.

Department of Health (1999). National service framework for mental health: Executive summary. Accessed 13 January. 2011http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006057.

Department of Health (1999). *National service framework for mental health: Executive summary.* Accessed 15 January. 2011http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4014501.pdf.

Falloon, I.R.H., Graham-Hole, V. & Woodroffe, R. (1993). Stress and health of informal carers of people with chronic mental disorders. [Electronic version] *Journal of Mental Health*, 2, 165–173.

Gray, B., Robinson, C., Seddon, D. & Roberts, A. (2008). 'Confidentiality smokescreens' and carers for people with mental health problems: The perspectives of professionals. [Electronic version] *Health and Social Care in the Community*, 16(4), 378–387.

Gray, B., Robinson, C.A., Seddon, D. & Roberts, A. (2009). An emotive subject: Insights from social, voluntary and healthcare professionals into the feelings of family carers for people with mental health problems. [Electronic version] *Health and Social Care in the Community*, 17(2), 125–132.

Guberman, N., Nicholas, E., Nolan, M. Rembicki, D. Lundh, U. and Keefe, J. (2003). Impacts on practitioners of using research-based carer assessment tools: experiences from the UK, Canada and Sweden, with insights from Australia. [Electronic version] *Health and Social Care in the Community,* 11(4), 345–355.

Kübler-Ross, E. (1969). *On death and dying.* New York: Touchstone.

Loughland, C.M., Lawrence, G., Allen, J., Hunter, M., Lewin, T.J., Oud, N.E. *et al.* (2009). Aggression and trauma experiences among carer-relatives of people with psychosis. [Electronic version] *Society for Psychiatry and Psychiatric Epidemiology,* 44, 1031–1040.

Maskill, V., Crowe, M., Luty, S. & Joyce, P. (2010). Two sides of the same coin: Caring for a person with bipolar disorder. [Electronic version] *Journal of Psychiatric and Mental Health Nursing*, 17, 535–542.

Morgan, J., Lowe, J., Lowe, L. & Rathod, S. (2010). Editorial: An international perspective on what carers want – The professional's dilemma. [Electronic version] *International Journal of Social Psychiatry*, 56(3), 211–213.

Pinfold, V. & Corry, P. (2003). *Under pressure: The impact of caring on people supporting family members or friends with mental health problems*. Rethink. Accessed 5 January 2011. http://www.rethink.org/applications/site_search/search.rm?oldterm=pinfold+and+corry+carers&startIndex=0&thisPage=1&term

Slade, M. (2009). *Personal recovery and mental illness: A guide for mental health professionals*. Cambridge: Cambridge University Press.

Slade, M., Pinfold, V., Rapaport, J., Bellringer, S., Banerjee, S, Kuipers, E. et al. (2007). Best practice when service users do not consent to sharing information with carers. [Electronic version] *British Journal of Psychiatry*, 190, 148–155.

Topor, A., Borg, M., Mezzina, R., Sells, D., Marin, I. & Davidson, L. (2006). Others: The role of family, friends and professionals in the recovery process. [Electronic version] *American Journal of Psychiatric Rehabilitation*, 9, 17–37.

Worthington, A. & Rooney, P. (2010). *Triangle of care. Carers included: A guide to best practice in acute mental health care*. The Princess Royal Trust for Carers and the National Mental Health Development Unit. Accessed 13 January 2011. http://professionals.carers.org/news/mental-health-and-the-triangle-of-care,6775,NW.html

BLANK PAGE
IN
ORIGINAL

URN 6111384

PPLDG Process Account One Summary

Year One

September 2010

Word count: 248 words

Looking back, I[1] realised how influential my personal and professional development (PPD) group had been in shaping my first year on the doctorate course. Following our first problem based learning (PBL) task to deliver a presentation on 'The Relationship to Change', our next exercise was to construct and share genograms of our families of origin. We used these discussions around diversity and difference to consider how our backgrounds could have an impact on our clinical practice. A 'shared learning' exercise with undergraduates reading dietetics followed, where we collaborated to discuss a hypothetical case scenario and the multi-disciplinary team (MDT) response.

We became accustomed to being task-orientated and so I was not sure what to expect from the group once we were no longer working towards an exercise. We agreed that filming a session, using the university's video suite, could give us an opportunity to observe ourselves. I was intrigued to watch the DVD as we had previously received feedback from our facilitator that we seemed to be reluctant to challenge each other in discussions.

We also considered the role our facilitator had played in influencing how we developed as a group, wondering how our new facilitator would feel, as we had spent the past year together, and whether this may return us to a previous developmental phase. I have enjoyed this year and am hopeful that we can continue to grow in confidence as a group, enabling us to focus on our personal development alongside our professional competence.

[1] I have written this account from a first person perspective to enable me to discuss and reflect on my role in the group.

PPLDG Process Account Two Summary

Year Two

July 2011

Word count: 215 words

At the end of the first year, I[2] strongly felt that our group had remained in the 'forming' stage of group process, whereas I was aware informally that other PPD groups seemed to have moved forward into later 'storming' stages of group process. Although we had successfully taken a risk in our second PBL presentation, the theme of our reluctance to take risks in the group still seemed to be an issue. For instance, I suggested that sometimes having sessions without an agenda may enable us to focus on our personal development, as it felt that the emphasis had been on our professional development so far. Whilst we all agreed that we were enthusiastic to try this out, more often than not a reason emerged that meant we could not dedicate a session to an experientially-based reflective group.

I have enjoyed our PPD sessions this year and am hopeful that we can continue to evolve our group identity, enabling us to focus more on our development both personally and as reflective-scientist practitioners over our final year of training.

[2] I have written this account from a first person perspective to enable me to discuss and reflect on my role in the group.

URN 6111384

Problem Based Learning – Reflective Account One

March 2010
Year One

Word count: 1990 words

The original 'problem'

The first Personal and Professional Learning Discussion (PPD) Group was at the end of my[3] first day on the doctorate course. We met our facilitator and following introductions, began to assign the roles of chair and scribe. Whilst the role of scribe was quickly filled, no-one seemed willing to put themselves forward as chair. After a pause, I volunteered for the role and whilst feeling comfortable with my decision, realised that I now felt somewhat more responsible for the progress and success of the task. The task itself was to produce and deliver, as a group, a presentation on 'The relationship to change'. Whilst there were some further ideas in our handouts, the task seemed vague and too broad. Looking back at my reflective journal, following that first session I wrote "feel that we've had a productive discussion, but that we are no further forward with the task.....PPD group is floundering due to the non-specific nature of the title". We concluded that initial session, with a mixture of relief at surviving the first day of the course and trepidation about the task ahead.

The group process

Our group had all volunteered to attend PPD sessions on Mondays at the end of formal teaching. I think this affected us in a couple of ways: firstly we often seemed to be making good progress compared with the other groups as we were always one session ahead and secondly we were very aware of, and consequently always stayed within, our time boundaries as group

---

[3] This account is written from a first person perspective to promote discussion and reflection of my own role in the group process and presentation task.

members needed to travel home. One of the disadvantages however was that we noticed a definite variation in our levels of energy and productivity across sessions depending on how strenuous we had found the day's teaching.

A difference I noticed between our group and others was that, at the second session, it was unanimously agreed that having the same people in the roles of chair and scribe throughout the task would promote group cohesion and task coherence. Again referring to my reflective journal, I wrote "I've been co-opted into the chair role for the whole of the task, am slightly concerned about being perceived as too bossy....". Following later reflection and discussion with members of my group, I do not feel that this was the case and I genuinely believe that it had a positive influence on group cohesion.

We began the process by focussing all our efforts on relevant theory, for instance consulting the literature for change models as we felt that, not only was the task ambiguous, but that we did not know what constituted an appropriate standard for work produced at doctoral level. Theory was something that we were all familiar with from our undergraduate degrees and so it felt reassuring. Additionally we noticed that we were initially looking to our facilitator to give us specific guidance on the task, but that her absence during the third session actually resulted in us approaching the problem more creatively.

Finally, we acknowledged the diversity within our group: some of us had been working in the National Health Service, others for a variety of different employers, there was a 15 year age range between us and we came from a mixture of different cultures and areas of the country. We found common ground in our experiences of starting an undergraduate degree and settled

on this as a way to acknowledge our diversity and encourage all members of the group to contribute to the task in a meaningful way.

The presentation

We recognised the importance of delivering our presentation using varied formats to account for the diversity of learning styles in our audience (Honey & Mumford, 1986). We began with photos that represented change to us and used a role play based on our collective experiences of beginning undergraduate degrees to illustrate the Stages of Change Model (Prochaska & DiClemente, 1982). We concluded the presentation with our reflections on the task and group processes over the preceding five weeks. We chose the Stages of Change Model (see Appendix 1) as it allowed us to draw parallels between our experiences of change and the experience of service users accessing psychological therapy. I found the model especially useful as, in addition to describing the six stages, it suggests techniques to support a person at each stage. It stresses the importance of involving service users in decisions about when and how they might be ready for change, which complements the collaborative nature of cognitive behavioural therapy (CBT).

Feedback was very positive, with our varied use of presentation styles and role play identified as maximising our audience's engagement. Our emphasis on self-reflection and working together were also highlighted as strengths. However both tutors commented that we could have expanded our use of psychological theory to strengthen other areas of the presentation, although subsequently I felt this would have limited the amount of reflection included.

Re-evaluation of the problem based learning task

I began re-evaluating the task by considering the original learning outcomes, the first of which was to 'understand the importance of collaboration rather than competition in learning'. I recognised its relevance to the first of Ten Essential Shared Capabilities (ESC) for Mental Health Practice (Department of Health, 2004); 'working in partnership'. These capabilities were developed, in consultation with service users and carers, to guide the training of mental health practitioners. During the PBL task there several occasions where one or two group members felt that a particular approach to the task was best (for example a critique of several models of change) which contrasted with the approach suggested by other group members (an emphasis on our own experiences of change). This required sensitive negotiation of the groups' priorities and we were able to resolve these differences constructively, a skill that has since been invaluable on my adult mental health placement. For instance, the multi-disciplinary team was divided on the issue of whether a particular service user was best supported by our team or the Learning Disability Service. I was able to clarify his level of intellectual functioning through psychometric assessment and write a balanced, evidence-based report summarising the issues to advise the team on a constructive approach that prioritised the service user's interests. Acting as chair for the PBL task, I had come to appreciate that it was not necessarily about how I would choose to solve the problem, but instead my role was to facilitate others in working together to find a solution.

The second learning outcome was to 'understand the importance of respecting diverse learning styles, differing areas of expertise and levels of knowledge' this has relevance to the second of the ESC; 'respecting diversity'. Throughout the PBL exercise I was aware that, although we all shared a common aim of completing the task, we had very different

experiences to date. This was apparent in our recollections of starting our undergraduate degrees and we used this diversity to draw parallels with experiences of service users accessing psychological therapy. For instance, we acknowledged some may have had negative interactions with services in the past, others may have perceived real benefits therefore positively influencing their expectations of future therapy and others still would have no experience of services. This realisation has influenced my assessment sessions with service users, as I encourage them to share their previous experiences and current expectations of psychological therapy and mental health services. I also actively encourage them to question anything they are not sure about during the sessions and to give feedback on what they are finding constructive and, mindful of the potential power differential between therapist and service user, provide regular opportunities to do so. This is consistent with the emphasis on collaborative empiricism in CBT, where the therapist and service user work together to identify difficulties and promote effective coping strategies (Wright, 2006).

Two further learning outcomes were to be 'able to reflect upon and value your personal experience' and to 'have gained a greater understanding of the processes of change'. These objectives are relevant to clinical psychology training as they enable the integration of knowledge from different sources, for example formal teaching, working with service users and supervision (Atkin, 2007). As described earlier, we focussed on our experiences of starting our undergraduate degrees, causing one group member to raise the issue that we viewed this experience with 'the benefit of hindsight'. Discussing this, I realised that we now knew the outcome of this period of change, we had all graduated successfully, and as a group we reflected on whether this had affected our attitudes towards our experiences. I concluded that I remembered the highs and lows rather than the routine and as a group we concluded that we felt more able to be objective about the beginning of our first degree compared with our feelings about starting this course. This may be comparable to service users' experience of therapy, as during

therapy they may not feel as if they are progressing, but with hindsight they may be more able to identify changes that have resulted. To facilitate this process, I encourage all service users to complete the Clinical Outcomes in Routine Evaluation measure (CORE Systems, 2010), either prior to attending the assessment session or at the end of their first appointment. Service users complete the same measure again at the end of their course of therapy to help them identify any changes in their daily functioning, subjective well-being, psychological distress and high risk behaviours.

Atkin (2007) proposed a model for integrating personal, scientific and clinical contexts for learning in theories of change; with personal context as a process of experience and reflection, scientific context as a process of research leading to evidence and clinical context as a process of practice followed by evaluating outcomes.

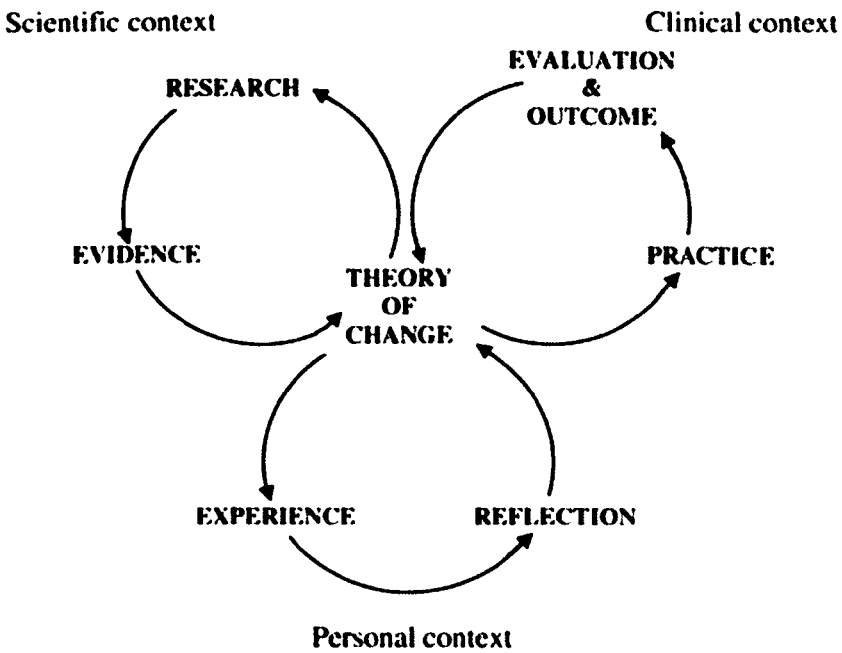


Figure 1. Contexts for learning in theories of change

Atkin (2007) Developing theories of change in clinical psychology training.

During my adult mental health placement, I have had the opportunity to begin to integrate these contexts for change during supervision. My placement supervisor encourages me to reflect on my work with service users, including its complexity. An example of this complexity is a service user who was referred to the psychology team for anxiety, which manifested as scratching his skin. During the assessment and history taking, it became apparent that he had mild learning difficulties, frequently experienced low mood and was also having difficulties in social situations. With the help of my supervisor I was able to reflect on his presentation and therefore discuss some possible approaches to working with him. Supervision has also enabled me to reflect on my personal development and I have become more aware of how much I have gained in confidence and competence since beginning the course five months ago, but also how much I still have to learn. This experience is consistent with that of other students on CBT training programmes (Bennett-Levy & Beedie, 2007).

Following the PBL task, I realised that I had found delivering the presentation more difficult than I had anticipated. In our group feedback one of the tutors commented on our 'articulation and audibility' remarking that we occasionally 'lost flow'. In discussion with my supervisor I identified this as a learning need and arranged to deliver a presentation on CBT for phobias to other members of the team at my placement, with the aim of gaining confidence in presentation skills. I am hoping to further develop my ability to present information clearly to others through co-facilitating a mindfulness-based cognitive therapy group with my placement supervisor later in the year.

Conclusion

In summary, completing the first PBL task exploring the 'Relationship to Change' provided our group with an opportunity to begin to get to know each other; including each other's preferred style of working as well as the roles we took within the group. It was at times challenging, although reflecting on the task has made me aware of how much we have learnt since beginning training, whilst the clinical work on my adult mental health placement has shown me how much we still have to learn together.

References

Atkin, T. (2007). Developing theories of change in clinical psychology training. *Journal of Family Therapy*, 29 (4) 321-325.

Bennett-Levy, J. & Beedie, A. (2007). The ups and downs of cognitive therapy training: What happens to trainees' perception of their competence during a cognitive therapy training course? *Behavioural and Cognitive Psychotherapy*, 35 (1), 61-75.

CORE Systems (2010). The core outcome measure. Retrieved March 4, 2010 from: http://www.coreims.co.uk

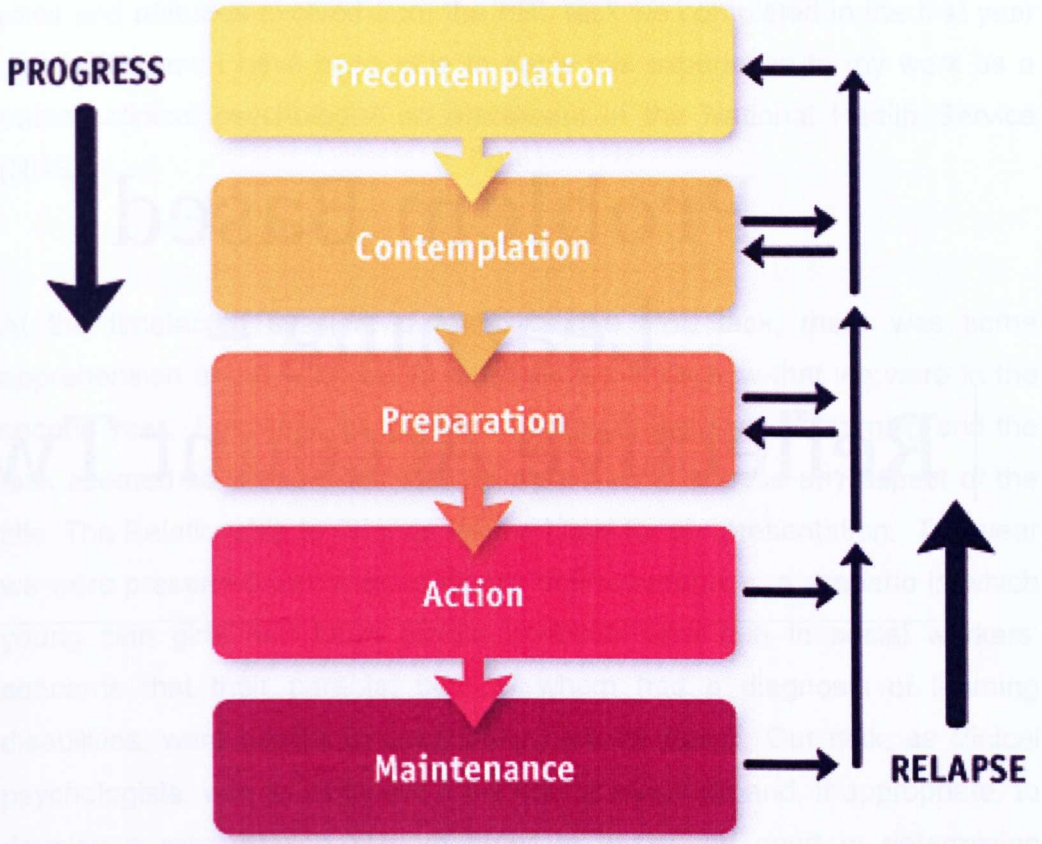
Department of Health. (2004). The ten essential shared capabilities: A framework for the whole of the mental health workforce. [Online edition]. London, UK: Department of Health

Honey, P. & Mumford, A. (1986). *Using your learning styles*. Maidenhead, UK: Honey.

Prochaska, J.O. & DiClemente, C.C. (1982). Trans-theoretical therapy – toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice,* 19 (3), 276-288.

Wright, J.H. (2006). Cognitive Behaviour Therapy: Basic principles and recent advances . *Focus*, 4, 173-178.

Appendix 1 – Stages of Change Model (Prochaska & DiClemente, 1982)



URN 6111384

Problem Based Learning – Reflective Account Two

Year Two

February 2011

Word count: 2268 words

In thinking about the problem based learning (PBL) task prior to writing this account it seemed logical to structure my[4] reflections around three main issues. Firstly the task itself; what was asked of us and how we decided to approach the task. Secondly how did we function as group; how had our roles and attitudes evolved from the PBL task we completed in the first year and lastly, how I have been able to apply this experience to my work as a trainee clinical psychologist on placement in the National Health Service (NHS).

At the timetabled session to introduce the PBL task, there was some apprehension about what would be expected of us now that we were in the second year. Last year, as we were all new to this style of learning and the task seemed so broad, I felt that we were free to choose any aspect of the title 'The Relationship to Change' as the basis for our presentation. This year we were presented with a more clearly defined problem: a scenario in which young twin girls had been placed in foster care due to social workers' concerns that their parents, both of whom had a diagnosis of learning disabilities, were unable to adequately care for them. Our task, as clinical psychologists, was to carry out a full risk assessment and, if appropriate, to develop a rehabilitation plan in order to assist the court in determining whether the children should be adopted or returned to their parents' care. In reading through the scenario I was struck by the complexity of the case, there seemed to be so many issues that were important to hold in mind. I realised these issues were operating at a range of levels; at an individual level, for example the children's needs as well as those of the wider family, i.e. the grandparents' desire to be involved in decision-making. There were also issues operating at a societal level, for example the extreme poverty experienced by the family, as well as the discrimination they faced as a result of their learning difficulties.

[4] I have written this account in the first person to allow for greater reflection on my role within the group.

Following this session, my personal and professional development (PPD) group met to decide how we were going to approach the task. We decided that, as for last year's task, electing a chair and scribe would ensure that we stayed focused and maximised our productivity. I had chaired the group last year, a role I had enjoyed, but was clear that this meant that I could not chair again this year, as I felt that this would position me as too dominant within the group. Again similar to last year there were several volunteers for the role of scribe but no-one seemed keen to put themselves forward as chair. Therefore someone suggested we play 'paper, scissors, stone' for the role as this seemed a light-hearted yet fair way to allocate the responsibility. Later on I reflected on this and wondered whether, as a group, we are still reluctant to do anything that may affect our valued identity as one of the most cohesive PPD groups.

At our first group discussion we considered the breadth and complexity of the issues and I was aware that, as a profession, clinical psychologists are uniquely placed to work in consultation roles. I believe that this is especially true in circumstances such as this, where the parties' positions have become polarised, with the parents demanding the return of their children, in contrast to the social workers' belief that the only solution was adoption. For the past five months I have been on placement with a Joint Community Learning Disability Team and recently had the opportunity to work in a consultation role. A young service user with mild learning difficulties who I had been constructing an extended risk assessment with had recently moved from a secure residential facility for adolescents to supported living in the community. At first he appeared to be settling in well and the staff team who supported him had experienced him as responsive and willing to engage with them. However over the last few weeks he had become increasingly withdrawn, spending long periods of time isolated in his bedroom. He had also started staying away from the house, on several occasions until the early hours of the morning, and was refusing to discuss where he was going and when he would be back with the staff team. Due to his learning disability

and previous history of offending behaviour the staff team had understandably become concerned about the risk of him being vulnerable to harm from others (such as being physically attacked) or of causing harm to others. I was able to use this PBL experience to hold in mind the differing positions of the service user, service provider and social services care manager as I chaired a review meeting with the aim of resolving some of these issues. For example I understood the importance of ensuring that the service user's point of view was at the forefront of our discussion (i.e. he didn't want to be accompanied by support staff on visits to the supermarket as he felt this would mark him out as different from his peers). Whilst also considering the support staff who were concerned that the young man didn't yet have the budgeting or planning skills to successfully negotiate supermarket shopping.

To address the sheer number of issues involved in the PBL scenario our group decided to each take one area to research in greater detail, before informally presenting our findings to the rest of the group at our next meeting. I thought it was important to consider the inter-generational impact of domestic violence on families, whilst other group members researched issues affecting parents with learning disabilities as diverse as attachment, government policy and discrimination.

At our next meeting one of the group suggested systemic formulation as a way of organising our ideas. She, along with another group member, had had the opportunity to be part of a reflecting team in family therapy sessions during her adult mental health placement and they both felt that a systemic approach could help to structure our thinking. I (and the rest of the group) had no experience of formulating systemically and were enthusiastic to learn from each other. As they outlined the formulation model, another group member suggested that this could comprise the basis of our presentation. We had already agreed that, in the time available, it was preferable to focus

on one or two main themes, exploring these in some depth, rather than to attempt to cover everything. Therefore we would all individually formulate the problem based on the same model (Dallos & Draper, 2006; in Johnstone & Dallos, 2006), and then combine our ideas to produce a 'super-formulation'. I really enjoyed this way of working, as it enabled us all to formulate and also ensured that everyone's ideas contributed to the presentation.

We decided that the presentation should provide a 'snap-shot' of a family therapy session which the other professionals had been invited to participate in. The two group members with experience of family therapy volunteered to be the reflecting team in the role play, with the rest of the group representing family members or different professionals working with the family. Based on our experience last year, we understood the importance of engaging the audience and using different modes of presenting the information, so we settled on displaying the formulation visually using PowerPoint whilst the role play would allow us to explore some of the challenges faced by the individuals involved. I suggested that rather than reading out the slides, we could use a circular questioning technique to explore the differing positions taken by the family and the professionals with the aim of encouraging them to acknowledge each others' differing opinions.

We received very positive feedback on the presentation, with one of the course team commenting on our "elegant use of systemic formulation" which was really encouraging as we had taken a risk in using a model that the majority of the group had little or no experience in. Both course team members commented on how cohesive our team working was and how it seemed that everyone's contribution was valued and I was pleased that these remarks echoed my own feelings about our PPD group. Reflecting on this later in a PPD session, one group member pointed out that some people had taken much larger parts than others during the presentation and that this had not felt awkward. I was able to understand this as a result of our

decreased anxiety and greater confidence in the group compared with last year, where it had felt important to ensure that all the work had been divided equally. This is consistent with later stages of group formation (Yalom, 2005) where group members feel confident that their investment is appreciated by other members. This led to a discussion of how we work together and I said that I felt that the majority of the group seemed to have a similar style of working (i.e. I know that I feel it is important to ensure that the task is completed to a high standard, but that it is essential to set time boundaries in order to focus myself) and I was curious about the members of the group who had different working styles. In contrast to last year however, one group member disagreed with me and explained how her working style was in fact quite different and that not using all the time allocated (plus some extra) had actually made her feel quite anxious. At times she had been worried about the amount of progress we had made but had found it difficult to voice her concerns as she very much felt in the minority. I was pleased that she felt confident enough in the group to disagree with the majority voice and was curious about whether our group might be about to enter the 'storming' phase of group formation (Tuckman, 1965; as cited in Halverson, 2008) that had so far seemed absent from our meetings.

Following the presentation, one piece of constructive feedback from a member of the course team was that it would have been useful for us to have spent more time discussing the evidence base and to have included some "positive non-blaming recommendations". Whilst accepting the validity of these suggestions, I felt we had made a deliberate decision that in order to enable us to cover the assessment in sufficient detail, it would not be possible to usefully make recommendations in the time available. When I raised this feedback again in a PPD session, another group member pointed out that we had all spent time considering the evidence base at the outset, however we had not felt the need to list every article we had read in our presentation. I reflected that this again showed our increasing confidence, both as a group and as trainees, as we had taken the evidence base and

applied it to our representation of the problem, whereas last year it had felt more important to explicitly show the 'evidence' behind our thinking.

One key issue that I have been able to take from this exercise and incorporate into my work on placement is that of discrimination. In the PBL scenario there were several examples of how discrimination can be quite subtle, with the result that it is sometimes easy to overlook for busy professionals. For example the parents with learning disabilities were illiterate and therefore unable to read the lengthy reports written for the courts by the professionals working with their family. In order to overcome this issue, the parents' solicitors had read the reports aloud, often on the morning of the court hearing. In my experience of working with people with learning disabilities on placement, this would often not be sufficient for an individual to actually understand the meaning or implications of the document. I have also now worked with people whose verbal expressive skills are far greater than their cognitive abilities, which has resulted in staff working with them becoming frustrated that their input appeared to be having no effect. Recently I worked with a man in his mid twenties who had struggled to gain employment, as he was not able to read or write and therefore could not complete the required application forms. He had visited the job centre on many occasions, but had become frustrated and despondent that he did not seem to be any closer to employment. However I believe that it is likely his ability to communicate verbally masked his cognitive and intellectual difficulties, meaning that he was not offered the support he needed to succeed.

In summary, I found this PBL task more rewarding than our previous one, as I felt it was really beneficial to have the opportunity to discuss these issues, which are directly applicable to our work on placement, with other trainees. In my placement I have learnt a considerable amount about the context of working with people with learning disabilities through clinical supervision and

it was helpful to have the opportunity to consolidate this knowledge through our discussions and delivering this presentation.

References

Halverson, C.B. (2008). Team Development. In C.B. Halverson & S. Ageel Tirmizi (Eds.) *Effective multi-cultural teams: Theory and Practice.* New York: Springer Science. 81–110.

Johnstone, L. & Dallos, R. (Eds.). (2006). *Formulation in psychology and psychotherapy.* East Sussex: Routledge.

Yalom, I.D. (2005). *The theory and practice of group psychotherapy* (5th Ed.). New York: Basic Books.

Clinical Dossier

BLANK PAGE
IN
ORIGINAL

URN 6111384

Overview of placements

Year Three

July 2012

Adult Mental Health Placement

October 2009 – September 2010

I gathered assessment information through clinical interviews as well as standardised assessment measures in order to collaboratively develop a psychological formulation and intervention strategy with adults experiencing a range of complex difficulties. I enjoyed using a range of psychological models to derive a formulation and am keen to develop my ability to work integratively further. During my adult mental health placement I worked with adults experiencing anxiety (post traumatic stress disorder, panic attacks, anxiety around eating, obsessive compulsive disorder, phobias) as well as those with diagnoses of depression, psychosis and bipolar disorder. I also gained experience of completing a thorough and appropriate risk assessment for every service user I worked with. I co-facilitated an Anxiety Management workshop with a counselling psychology trainee and a Mindfulness-Based Cognitive Therapy group with my clinical supervisor.

Learning Disability Placement

October 2010 – March 2011

During my learning disability placement I had the opportunity to work with service users and their families from a diverse range of ethnic, cultural and socio-economic backgrounds. This included an assessment with a service user, who solely communicated in a language other than English, carried out using an interpreter to enable her to maximise her input into the assessment. I adapted cognitive behavioural interventions and formulations for people with various levels of ability as well as carrying out cognitive assessments such as the WAIS III, BADS and AMIPB. I also undertook specialist risk assessment work with a young male service user with a diagnosis of learning disabilities and ASD who had previously been deemed to be at risk of sexually offending against children and animals.

Child and Adolescent Placement

April 2011 – September 2011

I worked with children and adolescents presenting with a range of psychological and emotional difficulties when on placement in a CAMHS team including anxiety disorders (obsessive compulsive disorder, phobias, panic attacks, PTSD), depression, difficulties with self-esteem and issues around eating. These problems have ranged from mild and transitory to difficulties that were having a major impact on the young person's life, for example resulting in a suicide attempt or prolonged absences from education. I was also responsible for considering the most appropriate care pathway for adolescents attending pre-group screening appointments and enabled others to develop their organisational skills and knowledge when working with two assistant psychologists to deliver this group cognitive behaviour intervention for young adolescents experiencing anxiety and depression.

Older Adults Placement

November 2011 – September 2012

At my current placement in older adults' services I am working with people aged from their late sixties to people in their nineties experiencing a range of difficulties including fear of falling, adjustment reactions and complex bereavement. I am also offering consultation to the multi-disciplinary staff team (nurses, occupational therapists, physiotherapists) regarding the assessment of depression and anxiety in patients who are recovering from stroke and training on the process of breaking bad news. I have also gained further experience on working with groups of service users in delivering an input on adjustment for older adults diagnosed with Parkinson's disease and a presentation on how a fear of falling can impact on the risk of falls to a Falls Prevention Group.

Specialist Placement

November 2011 – September 2012

I am currently on placement with a specialist team providing services to children and adolescents with disabilities and their families. I have gained experience of working as part of a multi-disciplinary team in the assessment, diagnosis and management of autistic spectrum disorders, social communication difficulties and other neurodevelopmental disabilities / delay in infants, pre-school and school-aged children and adolescents. This has included being part of the specialist Social Communication Clinic responsible for establishing and communicating diagnoses of developmental difficulties and ASD to parents, as well as work to support them in assimilating and managing this information. I have worked alongside my clinical supervisor in supporting parents who have understandably found it difficult to cope with the sense of loss such a diagnosis can result in.

URN 6111384

Case Report One – Summary

Cognitive behaviour therapy (CBT) with a female service user, in her mid-thirties, presenting with social anxiety.

Year One

May 2010

Word count: 235 words

This report has been fully anonymised, therefore some identifying details and all names have been changed to protect client confidentiality. The client concerned has provided verbal and written consent for their information to be presented in this report and to be shared with clinical and university staff as appropriate.

This report details a cognitive behaviour therapy assessment, initial formulation and intervention with a female service user in her mid thirties experiencing social anxiety. Jenny Green was referred to the psychology team as she was experiencing anxiety in social situations, including interacting with people as she feared saying the wrong thing. She found maintaining employment difficult due to the constant worry and need to analyse her behaviour and others' impressions of her. Her anxiety was maintained by high levels of avoidance, safety behaviours and pre and post-event rumination.

The intervention utilised cognitive techniques in challenging the dysfunctional assumptions and overestimation of risk that underpinned Jenny's social anxiety (Clark *et al.*, 2003; 2006), whilst behavioural techniques were used to address the safety behaviours and physical symptoms that maintained her anxiety and avoidance (Wells, 1997). Following the intervention, Jenny's difficulties were collaboratively reformulated and the outcome of the intervention assessed. Considerable improvements in Jenny's symptoms of social anxiety and psychological wellbeing were seen, with Jenny reporting increased self-confidence and also not engaging in deliberate self-harm (which she had done prior to commencing therapy). These improvements were also demonstrated using a standardised self-report outcome measure. On reflection, I believe the positive impact of this intervention could have been furthered by addressing Jenny's avoidance of anxiety provoking situations earlier in the intervention and using an objective brief outcome measure to gather qualitative feedback at the beginning of each session.

Case Report Two – Summary

A mindfulness-based cognitive therapy group for working-age adults with recurrent depression and /or anxiety.

Year One

August 2010

Word count: 250 words

This report has been fully anonymised, therefore all identifying details and names have been changed to protect confidentiality. The service users concerned have provided written consent for their information to be presented in this report and to be shared with clinical and university staff.

During multi-disciplinary team (MDT) discussions at the Primary Care Mental Health Team (PCMHT) it became apparent that there were a number of service users with symptoms of recurrent depression and anxiety, where rumination was perceived to have a significant role in maintaining their difficulties. Therefore in order to consider possible approaches to support the team, further information about the service users' backgrounds was collected from several sources: individual assessments, MDT clinical notes and referral letters, however it was not necessary to compile in-depth histories for each of the service users.

Following a discussion of the outcomes of the individual assessments and the construction of a group formulation in supervision, my clinical supervisor and I[5] agreed that it would be appropriate to follow the eight session protocol for group-delivered mindfulness-based cognitive therapy (MBCT) developed by Segal *et al.* (2002). A mindfulness approach does not strive to alleviate symptoms of distress instead change occurs through emphasis on the importance of 'being present' via meditation exercises (Kabat-Zinn, 2003). Therefore, it perhaps follows that no significant improvement was seen in group members' scores on self-report outcome measures. This apparent lack of change contrasted with the positive subjective written feedback and attendance rates of group members. Whilst accepting the limited improvement in outcome scores, other factors that may have influenced outcome were considered with the group. Finally, we discussed with participants how they could continue to use mindfulness in their daily lives.

[5] The first person tense is used throughout to allow for greater personal reflection.

Case Report Three – Summary

Extended risk assessment with a young man with a diagnosis of learning disabilities and a history of sexually inappropriate behaviour towards animals.

Year Two

April 2011

Word count: 227 words

This report is fully anonymised, some identifying details and all names have been changed to protect confidentiality. The client concerned has provided written consent for their information to be presented in this report and shared with clinical and university staff.

Mr Ryan Davies a 19 year old, White British man with a diagnosis of learning disabilities and autistic spectrum disorder was referred to the psychology service at the Community Learning Disability Team by his Social Worker. Ryan had recently moved to a supported living placement, after leaving a specialist residential unit for boys with sexually problematic behaviour and was referred for "psychology input around managing risk in the community". A previous assessment stated a "low risk of sexually offending against young children and a medium risk of sexually offending against animals", however there were no further details about the remit of this risk assessment. Therefore an extended assessment was needed to provide sufficient information (e.g. developmental history, risk behaviours, cognitive functioning) to establish risk.

The extended formulation suggested risk could be minimised through protective factors such as residence in supported living, support from his family as well as consistent and predictable boundaries and a programme of structured activities. There were no reports of sexually inappropriate behaviour since leaving the therapeutic community. Vulnerability may be increased by anxiety therefore it is essential that Ryan is supported to manage his anxiety. It was my[6] opinion that, when considering the risk of acting in a sexually harmful manner with animals or children, Ryan currently is defined as low risk.

[6] The first person tense is used throughout to promote personal reflection.

Case Report Five – Summary

Neuropsychological assessment with an older man presenting with concerns about his memory and cognitive functioning.

Year Three

May 2012

Word count: 220

This report is fully anonymised, some identifying details and all names have been changed to protect confidentiality. The client concerned has provided written consent for their information to be presented in this report and shared with clinical and university staff.

Mr Brookes an 88 year old man was referred to the psychology team by a doctor at the day hospital. She requested a psychology assessment of his cognitive functioning and also of his emotional wellbeing following a deterioration in his mobility and the loss of two close family members.

At my[7] appointment with him, Mr Brookes described the problem in terms of being "less able physically" and having a tendency to become "muddled". He was unable to give a clear indication of when he had first noticed changes to his memory and could not give any examples when he had experienced particular difficulty with his memory.

A comprehensive neuropsychological assessment was carried out over four sessions to investigate his emotional, cognitive and memory functioning using valid, standardarised measures. The findings of this assessment and the accompanying written report were shared with Mr Brookes and his carer at a feedback session to allow them opportunity to ask any questions.

The findings suggest that whilst Mr Brookes was clearly experiencing some specific cognitive deficits (not related to depression), which may well represent a significant decline from previous ability, these deficits do not appear to be impacting adversely on social and occupational functioning at present, thereby negating a diagnosis of vascular dementia.

[7] The first person tense is used throughout to promote personal reflection.

Oral Presentation – Summary

Year Two

September 2011

Word count: 317 words

This report is fully anonymised, some identifying details and all names have been changed to protect confidentiality. The client concerned has provided written consent for their information to be presented in this report and shared with clinical and university staff.

Looking back over the past two years, I[8] am aware of how much my confidence and skill in delivering therapeutic interventions has increased. I still feel fortunate that my first supervisor appeared completely undaunted by my relative inexperience and right from the start had confidence in me. Her attitude enabled me to simply ask when I wasn't sure, which in turn contributed to the development of my understanding of CBT assessment, formulation and intervention.

During my current placement with a child and adolescent mental health (CAMHS) team, I felt ready to begin working in new models and with the support of my supervisor I was able to explore a narrative, systemic focus in a piece of work with a family. Jasmine was a ten year old girl who lived at home with her mother, Rebecca. For around the past year, Jasmine had been hearing a self-critical voice in her head. The voice frequently criticised her at home and at school, for example telling her that any achievements were "just lucky". The voice was undermining her self-confidence, and so I was able to integrate an externalising technique into my predominantly CBT intervention with the aim of minimising feelings of guilt and blame within the family system. This approach helped me to reflect on not only how far I have come in my training but also how being competent in a range of models is an invaluable skill clinical psychologists bring to their work.

[8] I have written this account from a first person perspective to enable me to discuss and reflect on my development as a trainee.

Research Dossier

BLANK PAGE
IN
ORIGINAL

URN 6111384

Service Related Research Project

Evaluation of a pilot project to determine the impact of a multi-disciplinary assessment on service users and mental health practitioners.

Year One

July 2010

Word count: 2969 words [total word count 4655]

This report has been anonymised, therefore all identifying details have been removed to protect staff confidentiality. The colleagues concerned have provided verbal and written consent for their information to be presented in this report and to be shared with clinical and university staff as appropriate.

Acknowledgements

I would like to thank my field supervisor for all her help and advice in carrying out this research. I would also like to thank my placement supervisor for her continued support and for offering her comments on the draft of this report. Finally I would like to extend my thanks to the forward-looking team manager of our service and to all my colleagues who participated in the research.

Abstract

Introduction: Contrary to 'New Ways of Working' guidance that routine psychiatric appointments are not necessarily in the best interests of either the service user or the professional involved, this practice is common in the primary care mental health team (PCMHT) where the research was conducted. Therefore, a SRRP was designed to consider feedback from multi-disciplinary team (MDT) members' experiences of a project to pilot multi-disciplinary assessments (MDA). It was envisaged that a MDT approach at assessment, would enable a comprehensive exploration of the psychological and social needs of the service user, along with an opportunity for referral directly to the most appropriate resource.

Method and analysis: This research aimed to report and qualitatively analyse feedback received from MDT members following their participation in an existing project to trial MDA. Data was collected via a focus group for colleagues and was analysed thematically.

Results: Four main themes were identified, each including several sub-themes: experience of MDT staff, organisation of MDAs, relationship between MDT assessors and experience of service users.

Discussion: Staff felt that they and service users had benefited; however this appeared to be dependent on the relationship between the two assessors. There was confusion around the organisation and administration of the pilot, with staff reporting that they needed a clearer rationale and guidelines before commencing assessments. A key limitation was that the impact on service

users was assessed through feedback from MDT staff; therefore future research should aim to address this.

Introduction

Since its introduction by the Department of Health (DH) in 2003, New Ways of Working (NWW) has promoted a cultural change in mental health services by encouraging mental health practitioners and service users to reconsider values, ways of working and roles (NIMHE National workforce programme, 2009). NWW also addresses issues related to difficulties in recruiting and retaining psychiatrists. In many settings, service users routinely attended psychiatric appointments without any discussion of the rationale for regular appointments. This increasingly results in an unmanageable workload, leading to staff 'burnout' and poor quality service for patients requiring urgent attention. Whilst a move towards psychiatrists seeing only complex cases was welcomed in terms of more manageable workloads, there were reservations within the profession that this would result in psychiatry trainees being denied access to the routine presentations needed to develop knowledge and experience in the role (Vize, 2009).

A DH report published by the Social Exclusion Unit in 2004, identified concerns that involvement with mental health services and practitioners may actually increase social exclusion. The report identified two key themes: mental health services may inadequately promote social inclusion and mental health practitioners may have low expectations regarding service users' potential for recovery. Conversely, the idea of recovery, which has been developed and promoted in conjunction with 'survivors' of mental illness

highlights "self managing the mental illness" as one of the four foundations of recovery (Slade, 2009).

However, contrary to guidance that routine psychiatric appointments, in the absence of a clear purpose, are not necessarily in the best interests of either the service user or the professional involved, this practice is common in the PCMHT participating in this evaluation. Only a small proportion of those seen in the outpatients clinic have active involvement with a team member other than their psychiatrist, making it difficult for psychiatrists to respond quickly to requests for urgent reviews, as a result of their pre-existing caseloads. Retention of staff grade psychiatrists is problematic, causing difficulties in gaining relevant knowledge of additional resources available, both within the MDT and local community. This may result in poor continuity of care for service users, as they are frequently obliged to reiterate their difficulties to a new doctor. Additionally, as a staff grade may lack confidence to discharge apparently long-term service users after only one or two consultations, there is real potential for an individual to become entrenched in mental health services.

Therefore, a project to pilot MDAs was established to address these issues as it was envisaged that active involvement by other team members at the assessment stage, would enable a more comprehensive exploration of the psychological and social needs of the service user, along with an opportunity for referral directly to the most appropriate resource, whether within the team or community. Appendix One outlines the procedure used to determine service users' suitability to participate in the pilot and select appropriate assessors from the team.

It was anticipated that, over the four month duration of the pilot, between 12–16 MDAs would take place, involving approximately 10–12 members of team in total. Therefore a qualitative approach was chosen to assess the impact of the pilot, with the expectation that this would detect subtleties of experience that are impossible to obtain using a quantitative approach.

Aim

To report and qualitatively analyse feedback received from psychiatrists and other MDT members following participation in the piloting of a MDA. Feedback was obtained using a focus group for clinicians and took into account team members' perceptions of potential and/or actual outcomes for service users.

Method

Participants

A representative sample of ten professionals was invited to a focus group to discuss their expectations and experience of participating in the project. Nine colleagues attended the workshop, two male and seven female, each with experience of conducting between one and five MDAs.

Table 1 Composition of focus group by occupation.

Occupation	Representation in focus group
Psychiatrist	1
MHNP	5
Social worker	2
Occupational therapist	1

Procedure

The focus group took place at the conclusion of the pilot in April 2010. A schedule of areas to be explored was devised, with reference to relevant literature and the rationale for the pilot project (see Appendix 2). It covered five main topics: benefits and limitations of the new assessment process for staff, anticipated or reported benefits and limitations for service users and the actual or predicted impact of the pilot on retention of psychiatrists in the team. It was anticipated that the focus group would be a maximum of one hour long, as it was appreciated that team members had considerable demands on their time. All participants were asked to sign a consent form (see Appendix 3) at the beginning of the group. I[9] facilitated the group (actual duration 49 minutes) and digitally recorded it to transcribe the data verbatim. All data was anonymised prior to analysis.

Analysis

Thematic analysis was chosen as its flexibility enables 'identifying, analysing and reporting patterns within data' collected from a range of epistemological positions (Braun & Clarke, 2006, p79). Inductive thematic analysis was used as a means of identifying themes from the entire data set itself, as opposed to themes that 'fit' with my expectations of the benefits and limitations of the project, or those already highlighted by existing literature (for example Frith & Gleeson, 2004). Whilst there is debate about the relevance of analytic guidelines in qualitative research (for example Reicher, 2000), Braun and Clarke (2006) propose six over-lapping stages of analysis (see Table 2).

[9] This account is written from a first person perspective to promote reflection and discussion of my own position as a researcher.

Table 2 Phases of thematic analysis adapted from Braun & Clarke (2006).

Phase
1. Familiarise yourself with the data – transcribe and read
2. Generate initial codes – for all data collected
3. Search for themes – identifying themes from within codes
4. Review themes – generate a thematic map of analysis
5. Define and name themes
6. Produce the report – relate analysis to research question

This process was carried out identifying 36 initial codes represented by four major themes (see Appendix 4). Each data item (for example an opinion expressed during the focus group) was allocated to as many codes as appropriate. Coding was conducted at a 'semantic' level and did not involve detailed interpretation of, for example, the motivation behind participants' responses. The analysis was comprehensive in that the overwhelming majority of data was assigned to an initial code. In accordance with the flexibility of thematic analysis, I considered a pattern to be a theme if I felt it had relevance in answering the research question, as opposed to relying on, for example the frequency of each initial code (Braun & Clarke, 2006).

Reflections

I was aware of my position as a researcher, and wondered how being a trainee clinical psychologist impacted on my interactions with the participants who were my colleagues. I felt this could have influenced my research in a number of ways; I was aware of the diversity between me and my

participants, for example with regard to ethnic origin, I am a White British female. Just over half of the participants were of a White British ethnic origin with the remaining participants having a diverse mix of nationalities and ethnicities. Additionally several different occupations were represented and I was aware of my status as a trainee, in contrast to my participants who were qualified mental health practitioners. This diversity could have been helpful in facilitating a broad and challenging discussion, benefitting the research by making a range of perspectives accessible. However, the occupational diversity in the group may have made it difficult for the professionals in the minority (e.g. the psychiatrist) to express their views.

Results

Four main themes were identified, some including several sub-themes:

- experience of MDT staff
- organisation of MDAs
- relationship between MDT assessors
- experience of service users.

The themes were organised in this way to provide an understanding of the project to pilot MDAs from the perspective of staff who participated in the focus group (see Appendix 5).

Experience of MDT staff

One of the predominant themes throughout the data was the experience of staff delivering the MDAs, with two associated sub-themes, positive and negative effects. Whilst this may appear to simply reflect the focus group schedule, participants made reference to this throughout their feedback and not solely in response to questions regarding the benefits and challenges for the team (see Appendix 2), therefore I considered this to constitute a distinct theme.

Positive impact

Several members of the team identified the importance of reaching a consensus on the best course of action for a service user as a key outcome of any assessment. They felt that the MDA process had enabled them to reach a consensus more conclusively and in less time than if they had assessed the individual independently:

> "I mean considering that the word on the street is 'holistic approach', bio-psycho-social and all of that, this is the first time that I've actually seen it and felt that was a holistic assessment, that's worked out for the doctor, that's worked out for me, that's worked out for the patient because we've got a good clear picture of everything that's involved and what their needs are".

> "I think it was extremely helpful to do it together, first to not double the work and really to come up with a plan, possible diagnosis, what to do.

That saved me a lot of say figuring out myself and maybe I would have needed more time".

In addition to reaching a consensus in a shorter time, team members also felt that the assessment process had offered the opportunity to learn from each other:

"I've found it very helpful for my learning in a sense of working with the more complex ones and medication".

This was felt to be particularly important for new members of the team or those who were not anticipated to be working with the team for an extended period, such as trainee doctors:

"There was a doctor here,.....he was new to the service and the feedback from him was that it was excellent as he was not aware of the resources available locally so a member of the team being present made it much easier and saved time, signposting for example[10]".

Negative impact

In contrast, the two main challenges were felt to be an increase in time it took staff to complete an assessment and the time wasted if a patient did not attend (DNA):

[10] Data was transcribed verbatim, however for the purposes of the report I have abridged some quotations (denoted by .....).

"I think DNAs were frustrating, kind of rearranging or kind of being caught at the last minute to say so and so can't do it, can you do it? And jumping in and then getting kind of no-one turning up,.....it was quite frustrating".

The sub-theme of repetition during the assessment process arose several times and I decided it was relevant to several themes including the organisation of MDAs, experience of service users and the experience of MDT staff, described here by one colleague:

"I think if it's come from primary care, that the repetition of all the resources that we've looked at during that first assessment have already been explored, so.....I don't know if we've really got the time to be going over things twice".

I felt this sub-theme of repetition was clearly related to the confusion surrounding the organisation of the MDAs and this will now be considered.

Organisation of multi-disciplinary assessments

I identified two sub-themes: the role of triage in assessing an individual seen in a primary care setting, prior to a further assessment of their needs in a secondary care setting and the issue of who would be expected to take responsibility for care coordination. One participant raised the issue of triage:

"I think what is a bit confusing is that you are triaging in primary care and there are patients coming who have already been seen and I think it can be double your work".

Whilst another clinician explained that the intention of the pilot project had been to assess people who were new to the team and anticipated to have a need for secondary care services. Additionally there was confusion over the role of the second assessor and whether they would be assumed to take responsibility for becoming a care coordinator for the individual if a need was identified:

> "When I was assessing there wasn't an expectation that I would follow-up, I was there to support within the assessment. I didn't go in there thinking I could be the care coordinator or I might be the person doing that piece of work".

Whereas others anticipated that the assessment process could be used as a tool to delegate the responsibility of being a care coordinator:

> "Everything we assess we can't possibly take on and I might have capacity to do quite a few assessments but not the capacity to care coordinate".

Relationship between MDT assessors

Linked to the confusion surrounding organisation of assessments, there appeared to be differing experiences between staff of the division of responsibility during the assessment itself, with some reporting positive and empowering experiences:

"My experience was exactly that, it was a joint assessment so basically I was picking up on things that the doctor didn't necessarily pick up on and you know vice versa, whatever I wasn't sure about I would question the doctor on behalf the client. So it worked".

Where others felt that their ability to contribute relevant skills and knowledge to the assessment had been overlooked:

"I wondered whether it needs to be a bit more interactive, because my experience was the doctor just asking all these questions.....".

Experience of service users

Positive impact

This led onto the idea that, only where team members had a mutual respect for each other and a good working relationship, would service users benefit:

"It's about the relationship that exists between the two clinicians and whether they comfortably and harmoniously can work together..... to the benefit of the patient".

Several clinicians also felt that the MDA process had benefited the service user, by focussing on recovery or by enabling one of the members of staff to act as an advocate on their behalf:

"trying to I guess offer the client themselves time with the doctor but not have family come in, you can almost step in as an advocate for the person.....so I think having somebody else there helped and when I asked her afterwards she seemed to think so".

"I think there's certainly a group of people that don't need to come into the service so by giving them the resources and the information hasn't necessarily meant that they have come any further than just being an initial assessment. I guess it's being able to support them and demonstrate that actually they can manage with these resources. I think that the one I saw has been very accepting of that".

Negative impact

This view of the second team member as an advocate contrasted directly with other colleagues' perception that being assessed by two team members could actually increase a service user's anxiety:

"If somebody is paranoid and there are two people in the room that could be a bit of a difficulty".

Again the idea of repetition and the extra distress this may cause service users was raised:

"I mean you're always going to get a bit of repetition, of course you are, but people don't need to be coming and telling their story all over again".

The themes identified: experience of MDT staff, organisation of assessments, relationship between MDT assessors and experience of service users have implications for the continuation of the project. Staff felt that they and service users had benefited from the pilot, however consistent with literature on communication within MDTs (for example Donnison *et al.*, 2009) this appeared to be dependent on the relationship between the two assessors. There was confusion around the organisation and administration of the pilot project, with staff reporting that they needed a clearer rationale and guidelines before commencing assessments.

Several issues regarding the effectiveness of data collection and analyses were apparent. A key limitation being that the impact on service users was assessed through feedback from MDT staff; therefore future research should aim to address this, as accounts of service users and staff could differ considerably. Due to practical time constraints, this data was not available; however without this feedback the implications of the pilot are limited, as outlined by one staff member:

> ".....just to get a sense of what patients actually think about them [MDA] and is there anything we can take from them that's positive or that we need to make changes to".

Additionally whilst thematic analysis allows a flexible approach to the data, it is limited in its ability to comment on the language used by participants and is somewhat restricted in the depth of interpretation (Braun & Clarke, 2006). There is also a potential for 'anecdotalism' or an 'anything goes' stance,

where isolated examples are considered sufficient to comprise a theme (Bryman, 2004), and I have strived to avoid this by the careful use of quotations from the data.

As described earlier, the purposive sampling necessitated by the research question meant that my participants were already known to me. Additionally, one of the participants was responsible for line managing several of the other participants. This could have caused participants to feel discomfort when discussing issues, in particular criticisms of the pilot and may have led them to present an 'edited' version of their experience or opinions in an attempt to minimise any such discomfort (Hoskins & Stolz, 2005).

Finally, whilst these findings may be relevant to the experience of other team members, it would not be appropriate to presume that these results would be able to be generalised to other contexts, for example MDA at other PCMHTs. This is a methodological constraint when compared with quantitative research, which is frequently designed to allow for generalisation of findings to other populations.

References

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77–101.

Bryman, A. (2004). *Social research methods* (2nd Ed.). Oxford: Oxford University Press, 505–521.

Donnison, J., Thompson, A.R. & Turpin, G. (2009). A qualitative exploration of communication within the community mental health team. *International Journal of Mental Health Nursing*, 18 (5), 310–317. [Online edition].

Frith, H. & Gleeson, K. (2004). Clothing and Embodiment: Men Managing Body Image and Appearance. *Psychology of Men & Masculinity*, 5 (1), 40–48. [Online edition].

Hoskins, M. & Stoltz, J. (2005). Fear of offending: Disclosing research discomfort when engaging in analysis. *Qualitative Research,* 5 (1), 95–111. [Online edition].

NIMHE National Workforce Programme (2009). *New ways of working: implementation programme and sustainability* http://www.newwaysofworking.org.uk/content/view/35/446/. Accessed 9 June 2010.

Reicher, S. (2000). Against methodolatry: some comments on Elliot, Fischer and Rennie. *British Journal of Clinical Psychology*, 39, 1–6. [Online edition].

Slade, M. (2009). *100 Ways to Support Recovery*. Rethink. http://www.mentalhealthshop.org/products/rethink_publications/100_ways_to_support.html. Accessed 9 June 2010.

Vize, C. (2009). *New Ways of Working for Psychiatry*. http://www.newwaysofworking.org.uk/content/view/59/470/. Accessed 9 June 2010.

Appendix 1 – Multi-disciplinary assessment selection procedure

The selection of new referrals appropriate for inclusion in the pilot was made, by the team manager, at a weekly allocations meeting following a discussion of information provided in the referral letter. Any indicators of psychological or social needs, in addition to a possible requirement for medication, conferred inclusion in the pilot. Conversely, any indicators that a single contact with the PCMHT may be required (such as a routine psychiatric consultation prior to a referral for gender reassignment surgery) precluded involvement in the pilot. Following identification, by the team manager, of the most appropriate MDT member to participate in the joint assessment (mental health nurse practitioner, occupational therapist or social worker) an invitation to attend the assessment was sent by the medical secretary responsible. The appointment letter informed service users that there would be two professionals present at the assessment and offered the option to withdraw from the pilot project. Each assessment was anticipated to be an hour long.

Appendix 2 – Focus group schedule

Thank you for coming to this feedback session today. The aim of this session is to allow you to give open and unbiased feedback on your experience of participating in a joint multi-disciplinary assessment with a new service user. The multi-disciplinary assessments we are interested in took place from November 2009 and are continuing at present. We are interested in your views and opinions of the process and want to assure you that any information you share today will remain completely confidential, and that all feedback will be anonymised before it is discussed with other members of the team. Your participation today will help to guide and inform future decisions about the assessment process used here at the Primary Care Mental Health Team. Before we begin, does anyone have any questions?

1. Taking everything into account, what is your overall impression of the assessment process here at the PCMHT?

2. What do you perceive have been the benefits for the team of the multi-disciplinary assessment process, if any?

3. What have been the limitations or challenges for the team, if any?

4. Now considering the service users who attended a joint assessment; what do you perceive as the benefits for them, if any?

5. Again considering the service users who attended a joint assessment; what do you perceive as the disadvantages for them of participating in a multi-disciplinary assessment, if any?

6. Would you like to see the joint assessment process implemented, for all new assessments, in the longer term? If so, why? And if not, why?

7. What if any, has been the impact of the multi-disciplinary assessments on psychiatrist retention in the team? Or psychiatrist inclusion in the team?

8. Are there any comments or issues, relating to the trialling of a joint assessment process, that we have not yet discussed and that you would like to raise here?

Appendix 3 – Consent form

University of Surrey – PsychD Clinical Psychology

Consent to course work assignments

I understand that _____, trainee clinical psychologist would like my permission to use any information resulting from today's focus group to compete a course work assignment (service-related research project).

I understand that the work will not contain any information that would reveal my personal identity i.e. my name, place of work, or any other identifying details.

I understand that I do not have to allow the information I give today to be used in this way. I can change my mind and refuse consent at any stage.

Signed:

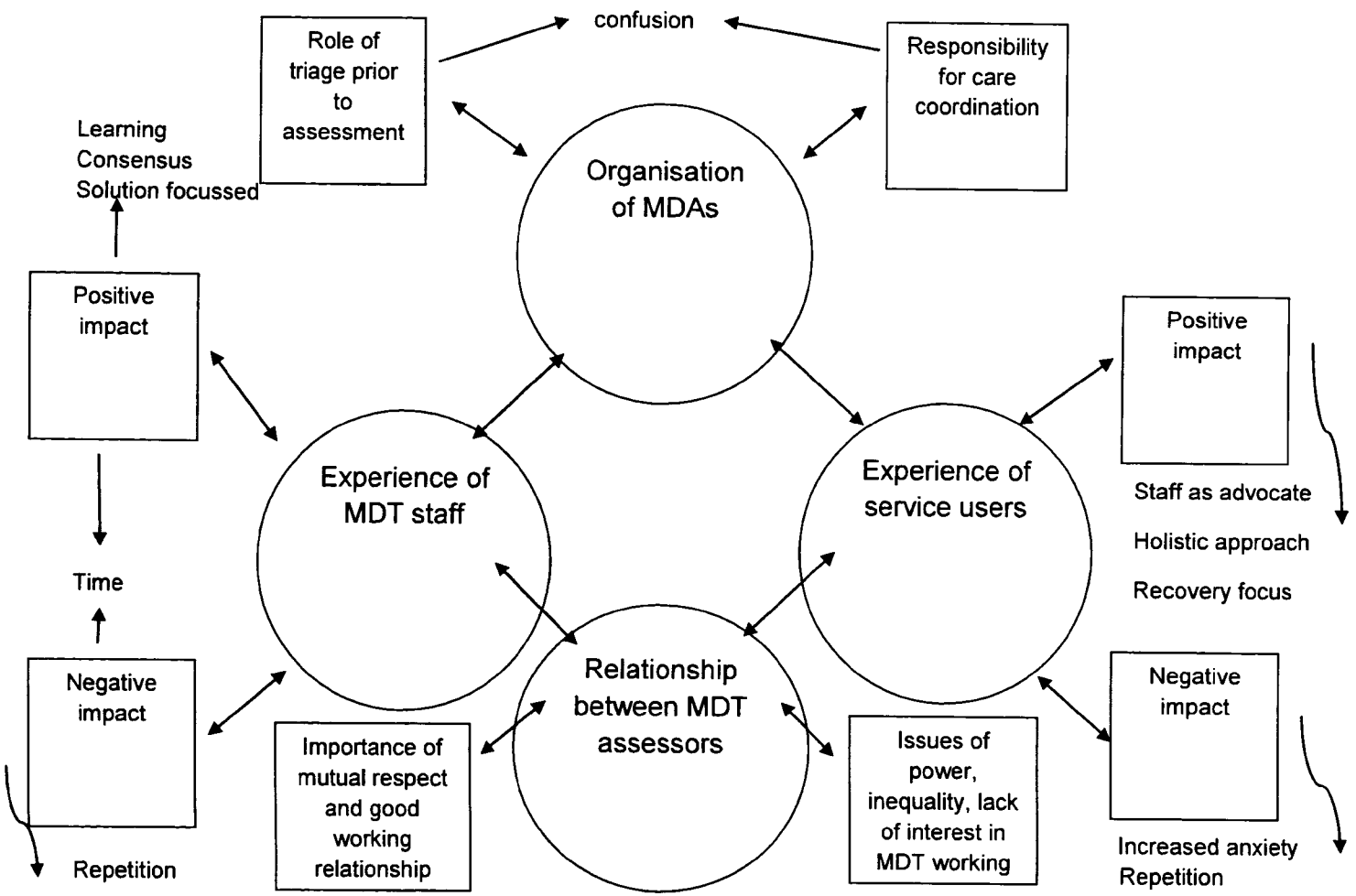
Name:

Appendix 4 – Complete set of initial codes identified

Experience of MDT staff	Experience of service users (SU)
Saved time / immediate outcome Increased complexity of cases **Clarity of outcome** Poor use of staff time Poor use of staff skills **Benefit of other clinician's skill** DNAs waste clinicians' time 2nd clinician able to act as advocate (helpful for doctor) **Benefits of holistic assessment** **Local knowledge helpful for new staff members** SU can't 'divide' staff **Repetition is frustrating** Choice re: care coordination 2nd clinician offers alternative perspective **Good use of staff skills** Saves unnecessary request for care coordination	Difficult for paranoid SU **Client choice** Client independence Difficult for anxious SU **Saves time for SU** Emotionally easier for SU Repetition of information is reinforcing for SU **2nd clinician able to act as advocate** No need for SU to repeat information **Benefits of holistic assessment** Repetition of information is frustrating
Relationship between assessors	Organisation of MDAs
Inequality of clinicians **Equality of clinicians** Disagreement between clinicians Agreement between clinicians is reinforcing for SU Previous experience of joint work **Joint work improves relationship between team** **Increases inclusion of psychiatrists/junior doctors in team**	**Confusion re: triage** Triage useful **Poor organisation of pilot** **Lack of clarity re: roles** Interest in feedback from SU **Confusion re: responsibility for care coordination**

Note: Codes are presented in the order in which they appear in the data. Initial codes associated with a higher prevalence (frequency of occurrence) are shown in **bold** type.

Appendix 5 Thematic map of analysis showing four major themes and associated sub-themes



Appendix 6 – Arrangements for feedback of results

The outcomes of this Service Related Research Project will be disseminated to the Primary Care Mental Health Team on Wednesday 7th July 2010 at the team's regular 'lunchtime academic presentation'. All members of the team will be invited to attend, regardless of participation in the focus group. All results will be anonymised to ensure that individual participants are not identifiable from their responses. Recommendations for the team will include:

- A team-wide consultation prior to commencing any future pilot projects / research
- Presentation of a clear rationale to the team, along with practical guidelines, for participation in any project
- Identification of one member of the team to act as a 'project manager' responsible for administration of the research
- A greater emphasis on obtaining feedback from service users on their experiences of the project / service received
- At the completion of any project / research, consultation with other MDTs in the wider locality to share findings and experiences of the pilot project.

Surrey and Borders Partnership NHS
NHS Foundation Trust

Vicki Woolcock
Trainee Clinical Psychologist
Redhill, Reigate & Horley PCMHT

Redhill Reigate & Horley Primary Care Mental Health Team
Shaw's Corner
Blackborough Road
Reigate
Surrey
RH2 7DG
Tel:01737 272301
Fax:01737 272348

9 July 2010

Dear Vicki

I am writing to thank you for presenting the findings of your Service Related Research Project to the team on Wednesday 7th July. We are appreciative of all your work on the project to trial a new assessment process at our service. Additionally it was both informative and helpful for the team to hear the outcomes of the project and your presentation encouraged an interesting discussion within the team.

Yours sincerely

Shahieda Sujee

Service Manager
Redhill, Reigate & Horley PCMHT

Hampshire County Council

SURREY

What role, if any, can companion animals play in recovery from serious mental health difficulties?

Major Research Project

Year 3

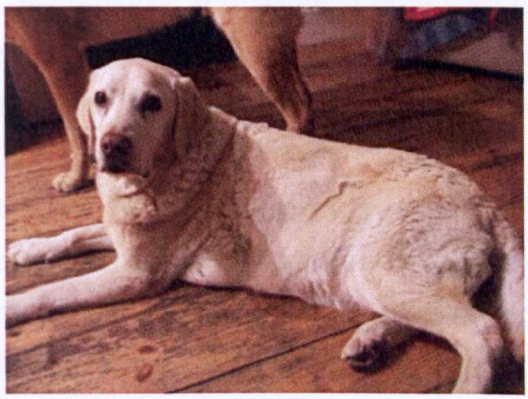
July 2012

BLANK PAGE
IN
ORIGINAL

Research acknowledgements

I would like to thank my supervisor, Prof. Arlene Vetere, for her expertise and support during the completion of this research project. In particular, I appreciated her enthusiasm for my research question and her understanding throughout. I would also like to thank the service users who took part in this research; their openness in talking about their experiences of mental health difficulties was both inspiring and humbling.

My final thanks go to my family; to Rich, for always being there, to my parents for volunteering to proofread the draft and to Heidi, Ivor and Hattie. This research is dedicated to Heidi, the best friend a person could ever have.



To Ivor, who provided endless excuses to stop working and go for a walk instead.

And to Hattie, whose help in completing the literature review was invaluable!

BLANK PAGE
IN
ORIGINAL

Abstract

There is widespread, popular belief that contact with companion animals can be beneficial for people across the lifespan. However, a review of the evidence-base reveals that this is not as straightforward as might be expected; with over four decades of human-animal interaction research reporting mixed findings regarding benefits of pet ownership. Whilst it has been hypothesised that pets may be of particular benefit for people who experience social exclusion and therefore isolation; there is a notable lack of research exploring the role of companion animal ownership in people with experience of mental health difficulties. Furthermore, the concept of recovery from mental health difficulties has been redefined; with an emphasis on personal recovery as a means of living a fulfilling life alongside any mental health challenges. Accordingly, a qualitative grounded theory methodology was used to explore what role, if any, companion animals can play in their owners' recovery from mental health difficulties. Semi-structured interviews with ten service users, all of whom currently owned pets and were recruited through mental health charity support groups, were used to generate a theory of the influence companion animals can have on recovery. A triangular interaction between three core concepts constructed from the data: responsibility, reciprocity and relating, together with two overarching categories: recovery and identity, offered an explanation as to how companion animals can influence recovery. These findings are discussed in the context of current literature, clinical implications for mental health service providers, in particular the need to acknowledge the potential importance and complexity of human-animal relationships, and lastly future research directions.

BLANK PAGE
IN
ORIGINAL

List of tables

BLANK PAGE
IN
ORIGINAL

List of figures

BLANK PAGE
IN
ORIGINAL

Contents

BLANK PAGE
IN
ORIGINAL

Introduction

Recovery has been redefined. The established (often pessimistic) perception of outcome for service users with serious mental health problems has been replaced by an emphasis on recovery for all (Roberts & Wolfson, 2004). This movement has changed what it means to recover; from a previous emphasis on *clinical recovery* as a return to 'normality' to a focus on *personal recovery* as a way of living a purposeful and fulfilling life alongside any mental health difficulties (Slade, 2009). The aim of this chapter is to explore how companion animal or pet[11] ownership[12] can be conceptualised within a recovery framework and to review the literature regarding the benefits of companion animals for both physical and mental health, as there is an established association between physical and mental wellbeing. At the end of this chapter the rationale for a qualitative research study considering what role, if any, companion animal ownership plays in recovery from mental health difficulties will be outlined.

One of the most important definitions conceptualises recovery as an individualised journey taken by a service user:

> "A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness". (Anthony, 1993, pp.18).

Additionally the emphasis on who is responsible for recovery has changed, from reliance on professional expertise to recognition of the service user as

[11] The terms companion animal and pet are used interchangeably throughout as both appear in the literature and in service users' responses; whilst acknowledging that companion animal implies a "companion" function in interactions (Mugford, 1980 in Francis *et al.*, 2007).

[12] There has been a recent shift to using "guardianship" to denote a more equal relationship between a human owner and their companion animal (e.g. Wood *et al.*, 2007), however I believe ownership more clearly reflects the legal position (pets are considered to be property) and is in more common use.

an 'expert by experience'; encouraging people to take responsibility for their own recovery (Roberts & Wolfson, 2004). Accordingly mental health services are increasingly organised around developing and supporting positive aspects of a service user's life, including their interests and priorities, in order to facilitate further recovery (Davidson *et al.*, 2006). This is evidenced by a recent faculty report into rehabilitation and recovery services written by the Royal College of Psychiatrists which took into account stakeholder views including those of staff, service users and carers (Wolfson *et al.*, 2009). Interestingly, this document acknowledged that service users wanted contact with animals or pets to be an integral part of inpatient rehabilitation services.

There is also evidence that service users consistently focused on the importance of "pleasure, play and other positive life events" (Davidson *et al.*, 2006, pp.155) in their recovery. They described how these opportunities offered respite from their difficulties, provided a focus and reason to continue in their recovery; as well as a chance to reconnect with the wider community and a sense of mastery despite the challenges they faced. This led me[13] to consider whether pet ownership could fulfil a similar role and therefore offer benefits for service users. I also wondered as a non-medical, self-directed intervention where it might fit within a personal recovery model.

The first recorded instance of animals being used therapeutically with people experiencing mental health problems dates back to the end of the 18th century where patients at the York Retreat, a residential facility founded by Quakers, were encouraged to care for small domestic animals as part of their rehabilitation (Tuke, 1813; in Slade, 2009). However despite long-standing interest, the therapeutic impact of animals is yet to be fully explored in mental health theory and practice (Walsh, 2009a). A psychologist, Boris Levinson, was among the first to attempt to research the human-animal bond after

[13] The first person is used throughout to enable greater reflection and discussion of the impact of the researcher on both the research process and its findings.

noticing how his pet dog could facilitate therapy with a child (Levinson, 1969; in Serpell, 1995) and consequently, over the last 40 years, research in this area has proliferated. Electronic search databases (PsychINFO, Web of Knowledge) were used to find relevant journal articles, which were then accessed electronically and downloaded. Advanced searches using combinations of the following search terms 'mental health', 'companion animal', 'pet' and 'mental illness' generated results which were then individually considered for inclusion in the literature review. Around 55 articles were found to be relevant to the scope of this project and this literature will now be considered in detail.

Companion animals and physical health

Research into the impact of pet ownership on physical health has tended to consider short-term effects and the longer-term consequences separately. There is a widespread perception, both among the general population and health professionals that "animals are good for us" (Wells, 2009, pp.524) however a closer examination of the research does not necessarily deliver the unanimous empirical support one might expect.

Short term effects on physical health

The calming effects of stroking a companion animal are well established. Nearly 25 years ago, research found that undergraduate students with positive or neutral attitudes to dogs had lower blood pressure and heart rates when patting a dog (Vormbrock & Grossberg, 1988). They found that participants' blood pressure was lowest when touching the dog, slightly higher when talking to the dog and highest when talking to another person (the experimenter). This suggests the importance of touch in decreasing physiological reactivity. This finding has been echoed recently in the popular press (Loveys, 2010) with the headline "Why petting your dog is the best form of stress relief" highlighting the continued interest in benefits of pet ownership. The article published the results of a survey of 1000 dog owners

conducted by a dog food manufacturer which found that over half felt more relaxed after interacting with their dog, whilst nearly half were more optimistic and less worried about everyday problems, such as job security.

Some of the most widely cited research regarding the impact of animals on physical health is that of Allen & colleagues (1991) which found the presence of a participant's pet dog decreased autonomic reactivity (lowered heart rate and blood pressure) during a stressful task (mental arithmetic). Female, working age participants acted as their own controls in this within-subjects experiment which found that in contrast, the presence of a supportive human companion (a close female friend) actually increased physiological reactivity and also decreased participants' performance. The researchers attributed their findings to the fact that whilst other people may be supportive, this does not preclude them from also evaluating performance. However participants in the 'dog present' condition received genuinely non-judgemental social support from their dogs (not many dogs can count backwards!), which effectively buffered them from the stressful demands of the task and therefore decreased their physiological reactivity. A further explanation may be that the presence of their pet dog engendered a positive emotional state in participants and it was this mood state which enabled them to cope with the stressful task (Cohen & Hoberman, 1983).

Long term effects on physical health

Whilst many review papers (e.g. Walsh, 2009a) cite the work of Friedmann *et al.* (1980) as evidence that pet owners had significantly higher survival rates one year after a heart attack, they frequently fail to mention that subsequent research found this effect was limited to dog owners and is hypothesised to occur because the dog confers a form of social support (Friedmann & Thomas, 1995). Additionally, although the authors concluded that the differences in survival rates may have arisen as a result of social conditions related to the presence or absence of pets, this is often not reported when the study is cited by others (Wright & Moore, 1982).

The relationship between companion animal ownership and the frequency with which owners visit their general practitioner (G.P.) has also been explored with variable findings. For instance Siegal (1990) found that older adults (aged 65 years plus) in the USA who owned pets had fewer visits to their doctor over a one year follow-up period than those without companion animals. This finding was based on a large number of participants (n=938) and the effect remained robust even when demographic characteristics and existing chronic health conditions (self-reported by participants) were controlled for. She hypothesised that dog owners' attachment to their pets and the dogs' function as companions, protected owners from stressful life events and therefore decreased their use of primary care health services. However, later research (Parslow *et al.*, 2005) found no relationship between pet ownership and utilisation of G.P. services over a one year period in a large survey (n=2551) of Australian older adults (aged 60-64 years). Worryingly, they concluded that pet ownership did not offer any physical or psychological health benefits for this population as respondents with pets reported decreased physical health (recorded using standardised outcome measures), higher use of medication for pain and higher levels of depressive symptoms. The authors query whether their findings might relate to differences between pet ownership (i.e. responsibility for a pet's care, which they recorded) and attachment to a pet, which may well be a relevant consideration, as in Siegal's (1990) study dog owners in particular reported feeling more attached to their pets, spending more time talking to them and were also more likely to say that their dog made them feel secure.

Further evidence that dog owners appear to attain greater health benefits than cat owners was provided by a controlled study considering the link between pet acquisition and physical health (Serpell, 1991). He found that whilst both dog and cat owners reported improvements to their general health (e.g. decreased headaches, colds) at one month following the arrival of their pet, only dog owners had maintained these health improvements at the end of the study period (10 months). Additionally they reported significantly

higher levels of physical exercise as a result of walking their new dog. This contrasted with the control group who did not own pets and did not demonstrate any significant changes in health or physical activity levels.

Interestingly, whilst two of these studies took into account participants' baseline levels of physical health, none of the research has considered the potential physical health benefits for people with mental health difficulties. This is disappointing given that it is recognised that individuals with mental health diagnoses experience significantly higher levels of physical illness and higher rates of mortality than the general population, with research calling for improved awareness from health professionals (Phelan *et al.*, 2001).

Companion animals and psychological health

Having reviewed existing literature regarding the impact of companion animals on physical health it seems to me that, with some possible exceptions (e.g. increased physical activity reported by new dog owners, Serpell, 1991); although it is important to acknowledge exercise also has positive effects for emotional wellbeing), many of the physical health benefits reported are mediated and/or moderated by psychological factors (e.g. social support, attachment to pets). Therefore research exploring the role of companion animals in promoting psychological wellbeing will be reviewed.

Facilitating social interaction

Severe and enduring mental health difficulties can have far reaching consequences for individuals, often reducing social and occupational functioning. Extended periods of difficulty and/or hospitalisation can cause service users to lose contact with networks of family, friends and colleagues, therefore becoming increasingly social isolated and lonely (American Psychiatric Association, 2000). A substantial body of evidence supports the

role of dog ownership in particular in promoting social interaction, for example walking with a dog significantly increased opportunities for conversations with unfamiliar people (e.g. McNicholas & Collis, 2000; Wells, 2004). Additionally qualitative research using community samples of both Australian and British dog owners found that dog walking facilitated more in-depth interactions and sometimes friendships with other dog owners due to a tendency to exercise dogs at the same times/locations (Knight & Edwards, 2008; Wood *et al.,* 2007). Therefore these additional social contacts can ameliorate loneliness and increase a sense of community integration as demonstrated by a quantitative survey; with twice as many people who did not have pets reporting that they frequently felt lonely compared with pet owners and pet owners also scoring higher on measures of social capital[14] (Wood *et al.,* 2007).

Some attempts have been made to determine whether these benefits are also applicable to populations with experience of mental health difficulties who incidentally may represent some of the most socially isolated people in society. In their mixed methods study of 177 service users with diagnoses of schizophrenia, schizoaffective disorder, bipolar disorder and affective psychoses Wisdom *et al.* (2009) found that 59 percent owned pets, with nearly three quarters of owners reporting that their pets were very important to them. Service users owned a variety of animals including dogs, cats, small animals (e.g. guinea pigs), poultry and horses. This is important as it demonstrates a wider impact of pet ownership that is not limited to dogs and cats; however it introduces methodological difficulty, as the interaction derived from contact with a guinea pig would be very different from that possible with a horse for example. Using a modified grounded theory methodology, they found that pets offered service users "an avenue for reconnecting with others" (Wisdom *et al.*, 2009, pp.433) which enabled them to seek out social support during their recovery. Similar findings emerged

[14] Social capital refers to the trust and reciprocity arising from social interactions within a community (Putnam, 2000 in Wood *et al.*, 2007).

from a quantitative survey of Canadian service users with serious mental health difficulties living in the community; with those who were pet owners demonstrating a higher level of community integration than service users without pets (Zimolag & Krupa, 2009). However, as many of these studies utilised correlational methodologies, it is important to acknowledge that a positive correlation between pet ownership and social contact does not necessarily determine causation.

Offering companionship, empathy and unconditional love

Wisdom and colleagues' (2009) research found that despite there being no difference in existing levels of social support between service users with and those without pets, companion animals were perceived to be a source of empathy, being able to understand and respond to their owner's emotional difficulties. Pets also functioned as family members for isolated service users, providing companionship and decreasing loneliness. Furthermore, qualitative research with individuals with diagnoses of mental health difficulties living in a supported housing project in the community, found that "connectedness" (Hunt & Stein, 2007, pp.172) was a major theme of interviews, with service users describing how their pets were family, how they felt loved by their pets and so less alone. This was the case for owners of pets as diverse as fish, reptiles, birds, small animals, cats and dogs. Service users in Hunt & Stein's (2007) research believed pets increased their "emotional stability" (pp.172) as they were able to talk to and confide in their pets, confident that they would continue to be there for them in a way people might not.

As research with mental health service users is limited, literature relating to the general population will be reviewed as earlier. Qualitative research based on focus groups with older dog owners (average age of participants was 60 years old) found that the psychological benefits of dogs represented a major category in the analysis (Knight & Edwards, 2008). Participants

described the relationship between them and their dogs as characterised by a mutually reciprocated unconditional love, offering companionship and comfort. Subsequent quantitative research using online surveys has consistently identified the benefits of companionship for pet owners who lived alone (Antonacopoulos & Pychyl, 2010). Many of Knight and Edward's (2008) focus group participants also believed that having a dog increased their quality of life and equated their dogs to family members, particularly where they had experienced bereavement of a partner. This finding is also common to research with people from ethnic minorities, where 97 percent of participants surveyed agreed they considered their pet to be a member of the family (Risley-Curtis *et al.*, 2006).

Alleviating mental distress

The literature regarding the role of companion animals in alleviating symptoms of mental health difficulties, e.g. depression, yields mixed results (Wells, 2011). Research carried out over 20 years ago into the relationship between pet ownership, pet attachment and mental health in older adults (65 years plus), found that multiple regression analysis of telephone survey data showed pet ownership and attachment significantly decreased depression where owners had experienced bereavement and had limited access to sources of social support (Garrity *et al.*, 1989). However they did not find any general association between pet ownership and either levels of depression or reports of physical illness. As discussed earlier, more recent research by Parslow *et al.* (2005) in fact identified significantly higher levels of depressive symptoms in older adults who owned and/or cared for pets. Whilst some researchers have concluded that taking responsibility for a pet's care strengthens the human-animal bond (e.g. Hunt & Stein, 2007), Parslow *et al.* suggest that this responsibility can also be viewed negatively, thereby increasing an owner's feelings of frustration, boredom and even guilt. Further evidence comes from research with mental health service users where, in certain circumstances, the responsibility of caring for a companion

animal caused the owner to feel overwhelmed and, believing they had failed, become depressed (Wisdom *et al.*, 2009).

Individuals with physical disabilities also experience marginalisation, frequently finding it difficult to participate in the community life able-bodied people take for granted, such as opportunities to work and take holidays, due to practical as well as social obstacles (Ramesh, 2010). The pervasive social exclusion of those with physical disabilities has parallels with the experience of people with mental health difficulties, and so I considered whether literature on the psychological benefits of assistance dogs[15] may have applications for mental health service users. Research found that recipients of assistance dogs had improved self-esteem and coped better with stress (Fairman & Huebner, 2001); were more relaxed and worried less about their health (Lane *et al.*, 1998) and reported feeling less depressed and/or anxious (Guest *et al.*, 2006; Valentine *et al.*, 1993). These findings may seem overwhelmingly positive and research in this area is not without methodological weaknesses (Sachs-Ericsson *et al.*, 2002). It is also important to note that assistance dogs receive substantial training prior to placement and that many assistance dog charities offer ongoing practical and emotional support to recipients. Therefore the experience of assistance dog beneficiaries may be inherently more positive than that of dog owners in general.

The impact of animal-assisted interventions (for example visits by a dog and volunteer team) on individuals with diverse needs living in residential settings has also been researched with variable findings. For instance, using observational reports from nursing staff, researchers found that a pet therapy programme decreased irritable behaviours in older adults who were psychiatric inpatients. However, the benefits of this programme did not differ

[15] Assistance dogs (or service dogs) receive specialised training to assist people with disabilities. They are typically provided by charities and have public access rights to enable them to accompany their owners at all times.

significantly from those of a group exercise programme implemented with the same patients (Zissleman *et al.*, 1996). While Walsh *et al.* (1995) found that a visiting 'Pets as Therapy' dog decreased levels of agitation shown by inpatients on a specialist dementia ward (as measured by a significant decrease in both patients' heart rates and noise levels on the ward).

The role of attachment

There is a view within the literature that individuals who form strong attachments to or relationships with animals are somehow incapable of forming adequate relationships with other people. However, recent evidence has found that the majority of people who have close relationships with animals also enjoy good relationships with other people (Archer *et al.*, n.d., in Archer, 1997; Walsh, 2009b). For example, quantitative research using a large sample of American college students (n=923) demonstrated that those students with a high level of attachment to their dogs also had high levels of attachment to (human) family members and friends (Kurdek, 2008). It has been proposed that dogs are uniquely affectionate, often approaching their owners simply to elicit attention and physical contact such as stroking (Serpell, 1995). Crucially, where pets are adequately cared for, this affection is non-conditional, consistent and could underpin the strong attachment relationships that frequently occur between people and their pets (Archer, 1997).

The use of attachment theory as a framework to understand human-animal interactions is not without controversy and is complicated by the fact that existing research is frequently methodologically flawed (Peacock *et al.*, 2012). In psychological contexts attachment refers to the development and maintenance of affectional bonds between people (particularly an infant and primary caregiver) in order to promote safety and security (Bowlby, 1982). Whilst some have argued that any relationship meeting these criteria can be considered in attachment terms (e.g. Margolies, 1999), others have proposed

that a framework based on supportive functions would be a more helpful way to conceptualise human-animal relationships (Collis & McNicholis, 1998). Archer (1997) concludes that, as in the case of adult attachment relationships (Ainsworth, 1989), both parties (i.e. person and animal) can fulfil the care giving role in certain situations in addition to being the recipient of care at other times. Evidence for the strong attachments people form with pets can be found in the extensive literature on pet loss. When a bereavement questionnaire was administered to participants, many owners reported a similar grief reaction following the death of a companion animal to that experienced in the aftermath of the death of a family member or close friend (Archer & Winchester, 1994). Bereaved pet owners described becoming pre-occupied with thoughts about the animal, initially experiencing a state of shock or denial, followed by feelings of sadness and eventually a gradual acceptance of, and adjustment to, their loss (Sharkin & Knox, 2003). Interestingly, stronger attachment bonds between owner and pet have been found to predict higher levels of grief following the loss of the pet in several studies (Archer & Winchester, 1994; Gosse & Barnes, 1994; Podrazik *et al.*, 2000).

However, research has found that where people have limited access to social support from others, a high level of attachment to companion animals is indicative of higher instances of depression, anxiety and psychosomatic symptoms (Antonacopoulos & Pychyl, 2010; Peacock *et al.*, 2012). A possible explanation for this finding comes from qualitative research with older women (aged 65 years plus) which conceptualised attachment to pets as following an inverted normal distribution, with owners failing to attain any health benefits at very low levels of attachment, and excessive attachment to pets predicting poorer health outcomes. Therefore pet owners reporting moderate attachment to their companion animals had the best health (Chur-Hansen *et al.*, 2009)

Rationale

As is evident from a review of the literature, despite widespread perception that "pets are good for us" (Wells, 2009 pp.524), there is a lack of empirically sound research concerning who may be able to benefit from pet ownership and what these benefits may entail. Positive, neutral and negative findings have all been reported by researchers, often within the same population (Chur-Hansen *et al.*, 2010). Additionally, where a positive impact on physical or psychological functioning has been identified, the associated causal explanation is frequently hypothetical and often remains untested.

Much of the research to date utilises a correlational methodology in making comparisons between pet owners and people without pets, which does not allow for detailed exploration of how variables may be interacting and giving rise to any reported effect (Walsh, 2009a). Comparison of pet owners with non-owners also limits the extent to which potential differences in personality traits and health-promoting behaviour (e.g. exercise) which might lead some people to acquire pets whilst deterring others (e.g. Wright & Moore, 1982) can be explored or whether the process of taking responsibility for a companion animal actually changes people in some way (Wisdom *et al.*, 2009). Additionally, research has frequently been carried out with self-selected participants (e.g. Knight & Edwards, 2008; Peacock *et al.*, 2012), who may be more inclined to report higher levels of attachment to their companion animals, as well as a more positive picture of their relationship with a pet. Accordingly there have been several calls for large scale, randomised controlled trials as would be standard practice in other fields of health care (e.g. Chur-Hansen *et al.*, 2010; Rijken & vanBeek, 2011) in an attempt to increase the potential to generalise findings.

Twenty five years ago the lack of a theoretical framework was identified as a difficulty for the field of human-animal interaction research (Netting *et al.*, 1987). Perhaps not surprisingly researchers have yet to reach a consensus

on the mechanisms underlying human-animal bonds. This is in part due to the apparent reluctance of mainstream health services to engage seriously with the impact of companion animal ownership (Serpell, 2008). Where efforts have been made to adapt attachment theory (Bowlby, 1982) in an attempt to increase understanding of human-animal relationships, the lack of agreement on how to measure attachment has hampered progress (Peacock *et al.*, 2012) with researchers arguing that a single, quantitative measure is unlikely to assess adequately the complexity of these relationships (Cohen, 2002). In a recent paper dedicated to exploring 'gaps' in the literature, the author emphasised the need for further qualitative research to identify new themes and to generate theories about the subjective meaning and impact of animals, with a view to using these theories as a foundation for more "ambitious" quantitative work (Chur-Hansen *et al.*, 2010, pp.142)

Furthermore, considering the reputed psychological benefits of companion animals, there is a curious lack of research with participants who have lived experience of mental health difficulties; an extensive literature search identified only a handful of papers. Therefore, in the context of the personal recovery movement, taking the need for a focus on mental health service users who are existing pet owners into account, the research question: "what role, if any, can companion animals play in recovery from serious mental health difficulties?" was developed. In terms of situating the research and theory generated in context, I considered it important to limit participation to dog and cat owners. I took this decision for several reasons: in the UK dogs and cats are the most frequently owned companion animals and are significantly more likely to be kept in the house than other pets (e.g. rabbits, guinea pigs); additionally as predatory species dogs and cats are more likely to demonstrate a wider range of behaviours in their interactions with owners than prey species (such as rabbits or mice).

Given the lack of consensus regarding potential benefits for the general population and the absence of an overarching theoretical framework, a qualitative grounded theory methodology was appropriate to address the research question with the aim of generating theory.

BLANK PAGE
IN
ORIGINAL

Method

Choice of methodology

A qualitative methodology was utilised as it offered a good fit with the epistemological and ontological position of both the researcher and the research question:

"What role, if any, can companion animals play in recovery from serious mental health difficulties?"

Qualitative methodologies were particularly suited to this research as they allow for exploration of a person's understanding of their situation and social relationships as well as the meanings they attribute to these (Tweed & Charmaz, 2012). A realist ontological position contends that different individuals may have a different experience of one situation or event, therefore the same situation may appear different depending on how it was studied or by whom (Willig, 2008). A social constructionist perspective was adopted as it assumes that the researcher themselves influences the research process through the assumptions they hold and the actions they take "we stand *within* the research process rather than above it, before or outside it" (Charmaz, 2006, pp.180).

Grounded theory was developed as an alternative to existing quantitative, deductive research methods which dominated social science research at the time (Glaser & Strauss 1967; in Straus & Corbin, 1998). It enabled the generation of new theories that were grounded in qualitative data, and 'emerged' during data analysis as opposed to testing hypotheses based on existing ideas. Grounded theory has a pragmatist tradition with a particular focus on action and process, or symbolic interactionism (Willig, 2008). This enabled me to address the research question by focusing on how people who have experienced mental health difficulties "create, enact and change

meanings and actions" (Charmaz, 2006, pp.7) both in their recovery and in the social processes of their human-animal relationships.

Data source

Interviews

Data were collected using semi-structured interviews with participants who had experience of significant mental health difficulties and were current pet owners. Interviews were chosen as they allow participants to recount their experiences in detail and to share their understanding of these experiences with the interviewer (Charmaz, 2006). Semi-structured interviews are an accepted method of data collection in research using grounded theory (Willig, 2008) and also enabled the use of clinical interviewing techniques for example to direct, clarify and expand upon participant's responses.

Ethical approval and considerations

Ethics

Prior to commencing the research careful consideration was given to possible ethical issues that could arise. For example, I was aware that participants may disclose problems in providing appropriate care for their animals, potentially due to the impact of mental health difficulties, and so I was prepared to discuss possible challenges and sources of support with participants. Ethical approval for the study was granted by the University of Surrey Faculty of Arts and Human Sciences Ethics Committee (see Appendix 1).

Informed consent

At the time of recruitment, participants were given an information sheet (either by a member of staff from the mental health charity or via email) detailing the rationale for the study along with an explanation of what taking part involved (see Appendix 2). Participants were given a minimum of 24

hours between receiving the information sheet and being invited for interview to allow them to fully consider their decision to take part. Prior to the interview they were again presented with the information sheet and given an opportunity to ask any questions before signing a consent form (see Appendix 3).

Participant wellbeing

Participant wellbeing was paramount throughout, with participants advised that they would be able to withdraw at any point during the interview itself or the data collection period, without the need to give a reason, and that this would not have any impact on services they received. Furthermore, participants were advised that if they wished, a member of charity staff could sit in during their interview or be available afterwards to discuss any issues that had arisen. No participants took up this opportunity for extra support.

Confidentiality

The information sheet and consent form advised participants of the confidentiality of their responses. They were also informed of the limits of confidentiality, for instance if the interviewer became concerned that the participant, another person or animal might be at risk of harm (this would be discussed openly). All transcripts were anonymised and all names of participants and their pets were changed. Hard copies of data were stored in a locked cabinet whilst electronic data were stored in password protected files.

Participants

Inclusion/exclusion criteria

Inclusion criteria were as follows:

- Participants should have experience of severe and/or enduring mental health difficulties that impacted adversely, resulting in

"clinically significant distress or impairment in social, occupational, or other important areas of functioning" and may have received a formal diagnosis (American Psychiatric Association [DSM-IV], 2000).

- Participants should feel they are at (or have some experience of) a 'recovery' stage in their mental health difficulties.
- Participants should be pet owners or should have owned a companion animal (specifically a dog or cat) in the last two years.
- Participants should have English language skills at a level equivalent to a native speaker.

Exclusion criteria were as follows:

- Potential participants should not feel unduly distressed as a result of their mental health difficulties at the time of taking part.
- Potential participants should not have a diagnosis of learning difficulties or other significant cognitive impairment.

Recruitment

Participants were recruited through contact with several national and local charities offering services for people experiencing difficulties with mental health. Participants attending community-based support groups were invited to take part in this research, through direct contact with group facilitators. Written information detailing the aims of the research and participation was made available to support group members and facilitators.

Charity support workers identified potential participants, explained the nature of the project and provided contact details for the researcher. As information on the project was also printed in several of the charities' newsletters, interested service users also contacted me directly. Information sheets and consent forms were distributed by staff or via email. I then discussed the project with interested individuals and arranged a mutually convenient time to conduct the interview if appropriate, thereby eliminating any possible risk of coercion to take part by support workers.

Sampling strategy

Grounded theory utilises a constant comparative method, whereby the process of data collection and data analysis occur in parallel (Strauss & Corbin, 1998). Employing a theoretical sampling strategy enabled the findings of earlier interviews to be used as a guide to shape the direction of later interviews. In my initial two interviews, both with male participants of working age (who were currently not able to maintain full-time paid employment due to their mental health difficulties) themes around the impact of mental health on employment were very prevalent. Both participants commented on the challenges of being a pet owner and maintaining full time employment, which made me curious about how pet owners who were not employed would respond. Therefore theoretical sampling was carried out alongside convenience sampling and the next three interviews were conducted with retired participants who had come forward from another charity. A flow chart of participant demographics is shown in Figure 1.

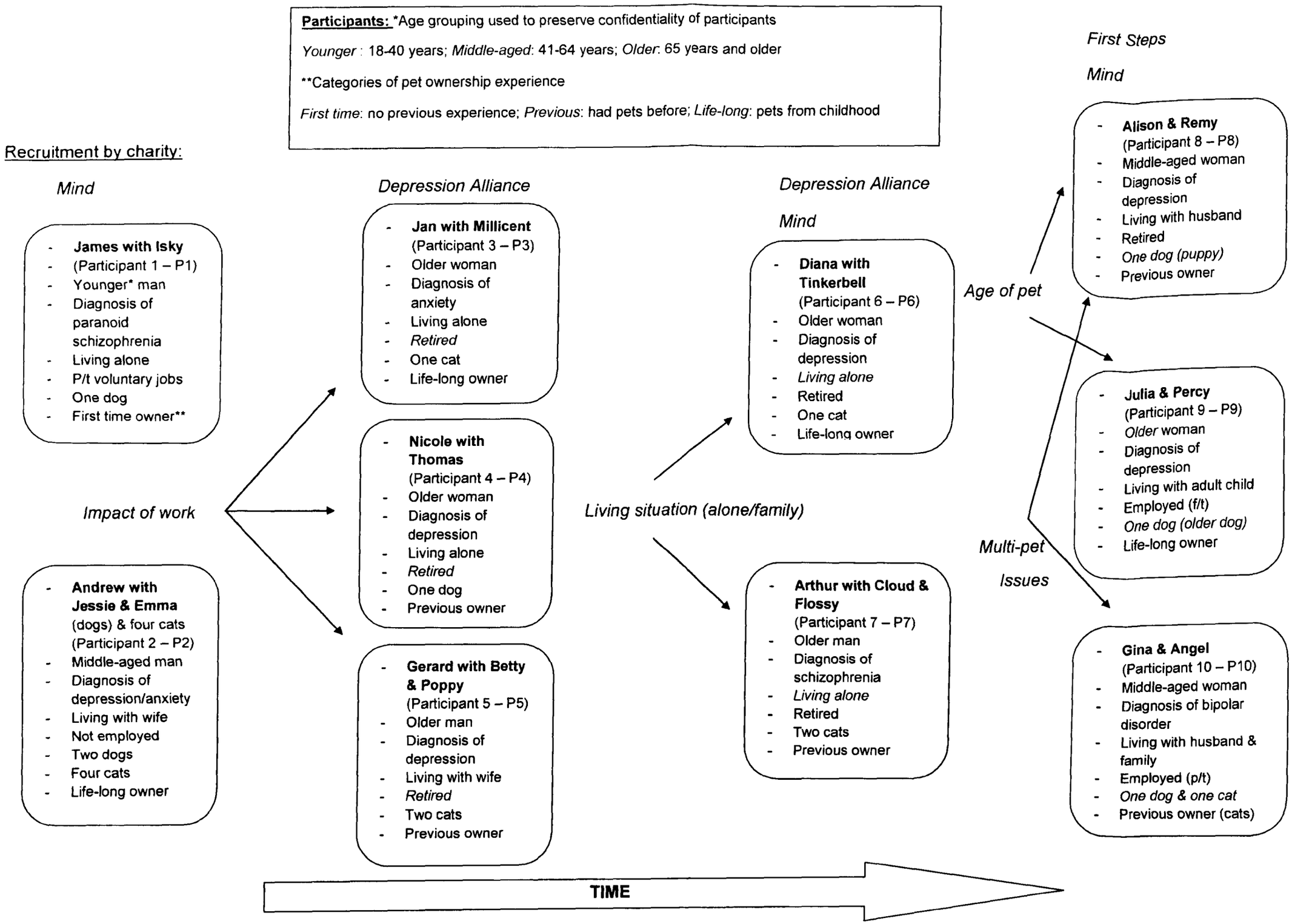


Figure 1 – Flow chart detailing process of theoretical sampling and participant demographics (n.b. all names of participants and pets have been changed).

Procedure

Interview process

An initial interview schedule was developed and piloted as described above. One of the men bought his dog to the interview with him, which gave me an opportunity to observe the interaction between them. In all I was able to meet four of the participant's pets and these informal observations offered me valuable insights into the context of their relationships with pets. The initial schedule enabled a detailed discussion of both anticipated and more unexpected issues in the men's recovery and therefore it was decided to use the schedule without modification in the next three interviews. The schedule was then amended following interview five, and again following interview eight (see Appendix 4), to take account of concepts emerging from the data (Charmaz, 2006).

Participants were given the option to be interviewed at the charities' premises (e.g. in a private therapy room or office) or at home; in all three interviews were conducted at participant's homes. Clinical interviewing skills were used to ensure that the interview was more structured than a normal conversation as well as to reflect on and clarify participants' responses.

Transcription

Each interview was digitally recorded and transcribed verbatim by the researcher. All personally identifying details were removed at this stage to maintain participants' confidentiality. Having a written record of each interview enabled reading and re-reading during data analysis.

Data analysis

A constant comparative process of data analysis was employed, where each interview was analysed both individually and in relation to all other existing interviews. This process allowed data to be grouped into related conceptual categories and these categories to be divided into sub-categories that acknowledge the difference within them (Willig, 2008). As coding progressed from initial line by line coding to higher levels of abstraction, the analysis itself developed from being more descriptive in nature, gradually becoming increasingly interpretative (Strauss & Corbin, 1990).

Initial coding

Line by line coding was used to preserve the detail and richness of the interviews, as I (in discussion with my supervisor) believed that to proceed with a more abstract level of analysis at this stage might have inadvertently diverted the analysis in a particular direction, thereby decreasing the fit and relevance of the research (Pidgeon & Henwood, 1997). Initial codes used participant's language (*in vivo* codes) to ensure their meanings and actions were represented in the analysis (Charmaz, 2006) (see Appendix 5).

Focused coding

Focused coding was used to increase the level of abstraction in the analysis, therefore the most relevant or frequently occurring initial codes were transformed to represent larger sections of data (Charmaz, 2006). Gerunds were used as codes to highlight actions and processes within the data, and Appendix 5 demonstrates how initial codes were taken forward as focused codes. Although typically codes moved towards a more abstract or conceptual level, this was not a linear process and constant comparison within and between interviews led to the redefinition of codes as required.

Axial coding and category development

Axial coding developed by Strauss & Corbin (1998) is a means of making conceptual links between categories. I used their frame in considering 1) conditions, the context in which the category operates; 2) actions/interactions, how participants respond within a situation and 3) consequences, the results of the actions or interactions taken by a participant. This framework was useful in considering both how focused codes clustered together and also how different clusters of codes interacted with each other (see Appendix 6). Constant comparison within and between interviews continued and conceptual diagrams were used to develop the theoretical model which is presented in the results.

Memos

I wrote memos throughout the analysis to take account of how my pre-existing knowledge, beliefs and assumptions may have influenced the process and the development of theory (see Appendix 7). Memo writing also facilitates the constant comparative process and can be helpful in defining the context and properties of codes and categories (Tweed & Charmaz, 2012). A process of clustering memos was also used to facilitate development of the theoretical model (Charmaz, 2006).

Credibility

To demonstrate the usefulness of this research it was important to consider the validity, reliability and generalisability (Tweed & Charmaz, 2012), however these constructs require adaptation in order to be relevant when applied to grounded theory methodology (Strauss & Corbin, 1990). Therefore the principles proposed by Yardley (2000) were used to assess the credibility of the research and are discussed in turn:

- *Sensitivity to context*

A literature review was conducted following data analysis with the aim of interpreting the findings in the context of existing research to develop a theoretical answer to the research question. The model also needed to be robust enough to accommodate negative cases (i.e. instances in the data that did not fit neatly into the theory). Therefore, negative cases were treated with consideration (Yardley, 2000), which gave rise to the idea that several categories in the model were best conceptualised as continuums (for examples see results).

Yardley (2000) also highlights the importance of situating the research and model within its social context as well as considering the impact of a researcher's personal characteristics (i.e. professional vs. service user involvement in mental health services) on the interview process. These issues were addressed through the use of theoretical sampling (see Figure 1) as well as an emphasis on researcher reflexivity during memo writing.

- *Commitment and rigour*

Commitment requires "prolonged engagement with the topic" (Yardley, 2000, pp.221) which I have demonstrated through my work with physically disabled service users and their assistance dogs prior to clinical training. Developing technical skill in qualitative research methods also demonstrates commitment (Yardley, 2000). Throughout the research process I have worked to develop my skills in the application of grounded theory by actively participating in a grounded theory special interest group (SIG) formed with peer researchers.

Rigour entails the thoroughness of data collection and analysis (Yardey, 2000). Yardley (2000) emphasises that it is not sample size which determines whether a piece of research demonstrates rigour. Instead what is crucial is the potential of the sample to "supply all the information needed for a comprehensive analysis" (i.e. theoretical saturation has been reached) (Yardley, 2000, pp.221). However, it is difficult to demonstrate that theoretical saturation has been achieved, as new insights are always possible and therefore theoretical saturation in both data collection and analysis should be treated as "a goal rather than reality" (Willig, 2007, pp.37).

- *Transparency and coherence (including independent audit)*

Transparency is concerned with the level of description of how data collection and analysis were carried out (Yardley, 2000), with a higher level of transparency achieved by allowing readers direct access to examples of transcripts and coding at all levels of abstraction (see Appendices 5-8). The grounded theory SIG was also used to increase transparency; as peer researchers we independently coded extracts of each other's data at a line by line and focused level before discussing similarities and discrepancies in the different analyses (see Appendix 8). Reflexivity and openness about the researcher's motivations and hopes for the project also increased transparency by allowing readers to consider how theoretical understandings may have been constructed (Yardley, 2000).

Coherence requires that the choice of qualitative methodology is justified by the epistemological position of the researcher and the nature of research question (Yardley, 2000). I outlined the rationale for using grounded theory earlier and as the project progressed have found this methodology helpful in answering the research question.

- *Impact and importance*

The research can impact at several levels: theoretical, practical and socio-cultural (Yardley, 2000). In this instance I have located the research within the existing literature (see discussion) and intend to maximise its theoretical impact through publication in a peer-reviewed journal. The socio-cultural impact has been considered in terms of theoretical sampling, for example the geographical location and personal characteristics of participants that may have influenced their responses to the research. Whilst the practical impact of the project has been considered by discussing the theoretical model with a focus group of mental health professionals.

The importance of a piece of research should be paramount throughout its design and implementation, for instance what change is likely to result (Yardley, 2000); therefore the introduction outlined the need for this research and the utility of grounded theory as a methodology for exploring gaps in the current literature.

Focus groups

In order to further enhance the credibility of the research, the input of two different focus groups; one for service users and one for mental health professionals, was used to consolidate developing theoretical categories, validate the results of individual interviews and consider potential implications of the research (Elliot *et al.*, 1999). Grounded theory is a methodology that benefits from the integration of qualitative data from a range of sources (Willig, 2008), a process of triangulation that supports the development of comprehensive categories.

The focus group for mental health service users took place towards the end of data collection, when an initial model had been constructed from interview data. Ten focus group participants were recruited from a support group for people with lived experience of mental health difficulties run by a local charity. Whilst none were current pet owners, several had owned dogs and cats in the past. Additionally the previous group facilitator had encouraged members to bring their dogs to the group as she believed they could have a therapeutic effect during sessions, for example by providing a neutral focus at times of high emotion. After outlining the purpose of the focus group, and gaining verbal consent to take notes on themes (with the understanding that individual responses would be anonymised) from both the current group facilitator and members, I encouraged an open discussion of the benefits and challenges of companion animals in the context of mental health difficulties using the interview schedule to guide the discussion. See Appendix 11 for themes constructed from the focus group.

The focus group for mental health professionals took place following the end of data collection and during the process of writing up. Three mental health professionals currently employed by a national mental health charity (participants had also been recruited from this charity) took part and verbally consented to me taking notes on the themes of our discussion. I outlined the research method and the resulting grounded theory of the role companion animals had in their owners' recovery and invited the group to consider the implications of this for both their individual service users and their delivery of services.

Reflexivity

Taking a reflexive position enabled me as a researcher to consider how my interest in the role of companion animals in recovery and the

values I hold may influence the research. This is consistent with a constructivist approach which acknowledges that the researcher's interpretation of data and findings is constructed as opposed to being 'discovered' (Charmaz, 2006).

To help make my values explicit and challenge any preconceptions, a peer-researcher interviewed me using the interview schedule designed for participants as a template to open up discussion. Throughout, it was clear I believed that, in principle, owning a companion animal could have a positive impact on recovery. However, I was ready to acknowledge that there were many challenges associated with pet ownership. I have two dogs and a cat and so I was often able to identify personally with the pleasures and difficulties of pet ownership described by participants. Additionally, most of the participants asked whether I had pets during the recruitment and interview process, so they were aware that I could empathise with some of the difficult situations they had faced. I was aware that for many of my participants, pets had been a major part of their whole lives, and for the first time I realised that, despite all the other changes in my life pets had remained an almost constant presence in my life since I was given a rabbit for my fourth birthday. However, I was very aware throughout the research process that my experience of pet ownership could act as a 'lens' through which I viewed other's experiences, and so I used memos to explore some of these issues. For example, how my assumptions may have influenced my interpretation of the data and the possibility that I may have had a tendency to minimise any reported difficulties in the owner-pet relationship or to attribute these to failures in the owner's ability to manage the pet, rather than to challenges caused by the animal's behaviour.

Prior to clinical training I worked as an assistance dog instructor for a national charity, training and placing assistance dogs with people with physical disabilities and also families with children with physical disabilities or autistic spectrum disorder. Working in a professional capacity enabled me to see the positive impact a dog could have on not only the person with a disability but also their family. The dogs provided practical assistance (such as retrieving dropped keys) to increase a person's independence; although in working with over 50 partnerships I observed many indirect benefits such as increased confidence, opportunities for social interaction and companionship in people who were often isolated. I believed there could be parallels in the potential marginalisation of people with physical disabilities and those with mental health difficulties and so my personal and professional experience led to the development of the research question.

BLANK PAGE
IN
ORIGINAL

Results

The aim of this research was to explore how owning and looking after a companion dog or cat may impact on a person's recovery from serious mental health difficulties. Data analysis was described in the preceding chapter and therefore will not be repeated here. Theoretical sampling generated rich data with a substantial number of initial codes constructed from the data using line by line coding. Further refinement through focused coding and memo writing resulted in 25 major codes. These major codes were able to account for all the companion animal related data in the interviews, whilst the findings of data regarding recovery (not in the context of companion animal ownership) were not analysed in detail as part of this project. Further refinement of these 25 major codes using axial coding, clustering and associated memos enabled their transformation into five theoretical categories comprising nine smaller sub-categories (see Table 1).

The triangular relationship between the three theoretical categories responsibility, reciprocity and relationship was constructed from the data as changes in any one category can impact on both the other categories. The model explains how these core interactions with companion animals are important in positively influencing the recovery of current pet owners from mental health difficulties.

Table 1 – Taxonomy of theoretical model

Theoretical categories	Subcategories	Example of major codes
Responsibility	Balance of responsibility	-Enjoying caring for "someone"
	Practical care	-Budgeting to meet financial demands e.g. veterinary treatment
	Committing to being well	-Staying well to avoid being separated from the dog
Reciprocity	Shifting focus towards recovery	-Animals distracting you from what's going on in your head (e.g. rumination)
	Putting the animal first	-Forcing myself to get out with the dog, even if I don't want to
	Investing in the future	-Feeling that you get out what you put into the animal
Relating	Company	-Seeing the animal as a family member or friend, acknowledging that "families come in all shapes and sizes"
	Comfort	-Perceiving animal as "unconditionally accepting"
	Communication	-Believing the animal is able to understand and respond to person's emotions
Identity		-Struggling to remember a life without animals
Recovery		-Animal acting as a catalyst for recovery

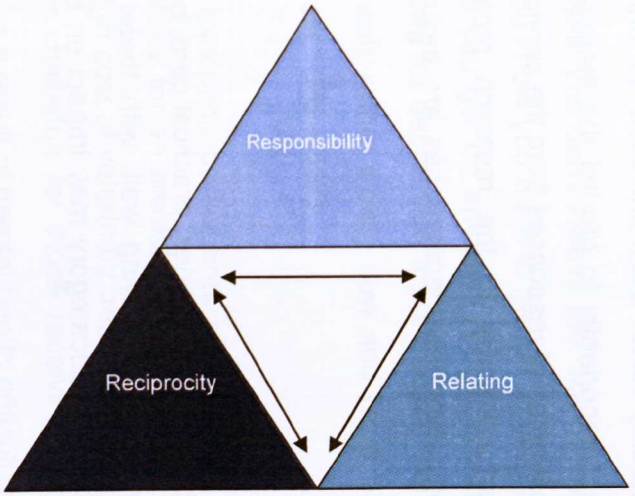


Figure 2 – The grounded theory of the role of companion animals in their owners' recovery from mental health difficulties

The theoretical model (see Figure 2) was developed after careful consideration, sorting and resorting of the relationships within and between each of the categories. This process was carried out by hand, with each of the categories and subcategories written on a piece of card and manipulated in space using a pin board (see Appendix 9 for an early theoretical model). In the interests of clear presentation the relationships between categories are not shown in detail in the diagrammatic representation, instead they are discussed in the narrative explanation of the categories that follows.

Anonymised quotations from participant interviews (identified by participant and line numbers) have been included to bring the categories to life and most importantly to ground the theory in the data (Charmaz, 2006). Examples of responses from the service user focus group which added credibility to the research project by validating the structure of categories/subcategories are included in Appendix 11.

Responsibility

Responsibility comprises three subcategories: practical care, balance of responsibility and committing to staying well; with these being interlinked i.e. a change in one subcategory may impact on both of the other subcategories.

Practical care

Participants described how the animal's physical needs (e.g. food, exercise) gave them an opportunity to take responsibility for another living being. Being responsible for maintaining a good standard of practical care was not without challenges; however, the animal's need for a consistent routine was often felt to have a positive impact, enabling owners to maintain their own routine and therefore recovery.

> "Well yeah I suppose it is a reason to get up, I have to get up because otherwise there's puddles and what have you and it gets me up and out everyday." (P1 – 12)

> "Well, you don't always feel like getting up you know so, then you know you have to get up to feed her...and things like that so you get up anyway. I think having a cat is a very good thing for depression myself, a dog would be better but I'm too, I walk rather slowly now and I'm a bit too old to take a dog walk." (P6 – 317)

Without exception participants raised some of the issues in taking responsibility for an animal. These included financial demands such as the high cost of veterinary treatment, which was perceived to be a particular challenge for those receiving benefits or unable to work full-time as a result of mental health difficulties.

> "When I was working it wasn't a problem, but obviously when you're on a low budget income, it does become a financial hazard, because they're just unexpected you know. That's where the issues become, do you keep them or do you...and you don't want to let them go so you're sitting there, having to

cut back and scrape the bottom of the barrel to make sure they're looked after sort of thing." (P2 – 95)

"You know apart from actually buying a dog which was £350, then the injections and the worming and the food and everything like that and when you're not working or you're on benefits you don't get any extra help for looking after a dog, um so that's quite tough on the financial restraints as well." (P8 – 523)

Participants with dogs were particularly aware of the difficulties in leaving them alone for extended periods and in several instances described how they made compromises in their own plans to make allowances for the dog's needs, which demonstrates how taking responsibility influences the category reciprocity.

"Obviously I'm going in and out, sometimes shopping or doing things but she never gets long periods on her own and that was a commitment again, we had to make that big decision, whether we were prepared to sort of be around for her." (P10 – 183)

"Well I was told when I got her not to leave her for more than four or five hours and so obviously that makes it tricky...so in that sense it is a bit of burden because obviously I can't do things I'd perhaps like to do sometimes." (P1 – 26)

Balance of responsibility

These dilemmas about how to accommodate an animal's needs in the context of the owner's current situation led to the development of the category: balance of responsibility. The majority of participants were clear that taking responsibility for their pet was a positive experience.

> "Well just getting out there for a walk, basically looking after them, feeding them, making sure they're alright, giving them a bath every so often, grooming them, just checking they're alright. It's the responsibility you give to them and what they give back to you." (P2 – 342)

However there were negative cases in the data, where at times participants felt their investment in the animal outweighed potential benefits of ownership.

> "He has huge energy and high expectations I think and you come in tired, you come in from two hours of dog walking and feed the dog and then [think] "for goodness sake go to sleep or something!" and [he's] like "no I've still got energy, I still want to do stuff"...Um I sometimes feel like a carer of a dog, you know, there's a lot of giving there, a lot of time is spent sort of satisfying what the dog needs." (P4 – 72)

Therefore findings in this category were conceptualised as a continuum, along with factors influencing participants' perception of their place along it (see Figure 4). For example, where participants felt supported by their partner, family or friends in caring for the

animal, they were more likely to perceive the benefits as overriding the challenges or to feel able to cope with a more 'demanding' pet.

> "You've got to remember that I'm in a partnership with my wife and so really even when I was ill before, that might have affected things with our previous cat and my wife was always there to make sure the animal was cared for." (P5 – 23)

> "If I was on my own I probably wouldn't have a dog, I probably would have gone for a pet but perhaps maybe a cat, even though I'm not a cat person, something that's not quite so demanding." (P8 – 512)

However, where participants were struggling to manage other caring responsibilities, for example looking after elderly relatives, or were experiencing current difficulties with their mental health they were more inclined to focus on the challenges of responsibility.

> "I stayed with her [elderly mother] in hospital for the last six days, I didn't go home. Yes she was prioritised over Percy, I um asked a friend, a friend that actually is with the support group. I rang him up and said can you come and collect my keys from me, go get Percy and he's yours, do what you like with him, I cannot cope." (P9 – 291)

> "I did worry a lot in hospital thinking I hope she [the cat] is being fed properly and he's [neighbour] not saying oh yes

everything's alright and she's run off, I got myself quite anxious." (P3 – 79)

A memo reflecting on Jan's comment above highlighted the potential conflict for an owner requiring hospitalisation i.e. worrying about her cat could be a motivation to make progress and return home however an increased level of anxiety might in itself affect a service user's rate of recovery. This memo was helpful in focusing my analysis on the tension between the balance of responsibility for the animal and the need for an owner to take care of themselves in order to successfully manage their pet. This led to the generation of the final sub-category of responsibility: committing to being well.

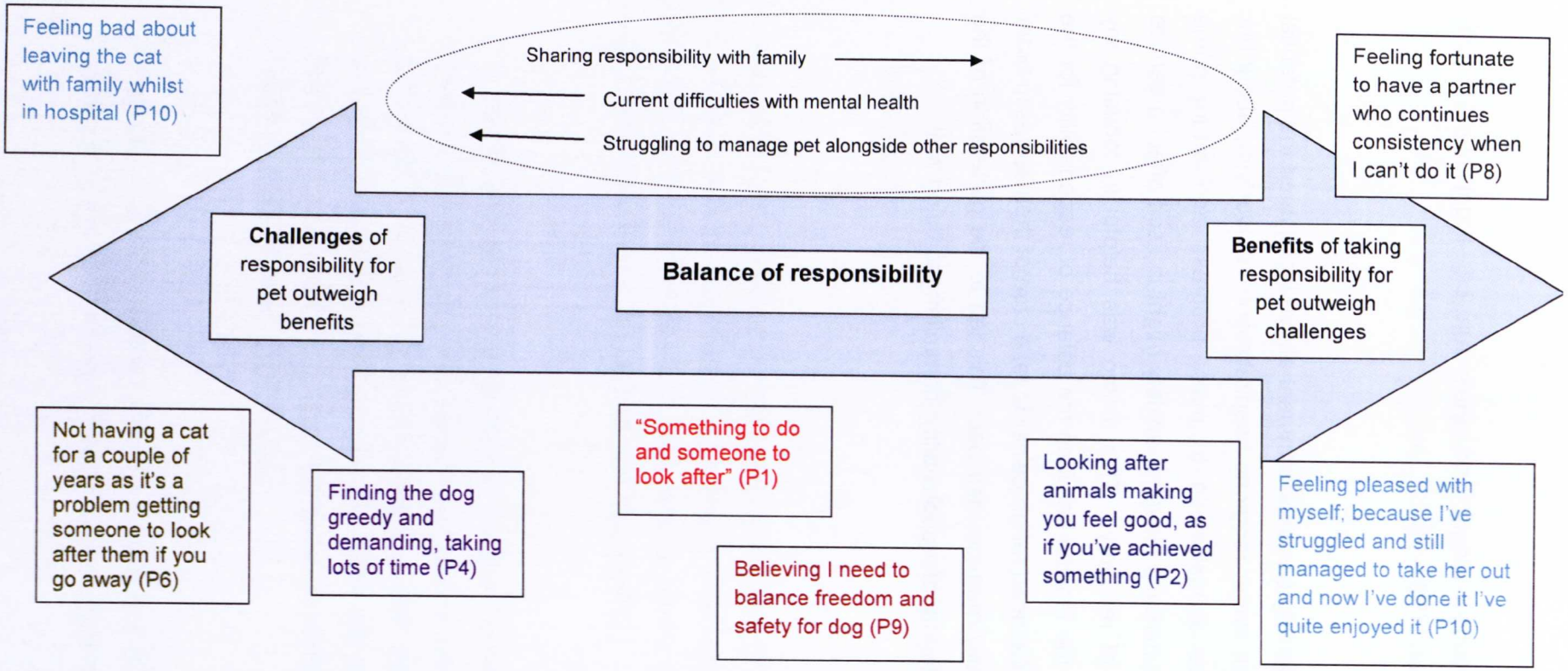


Figure 3 – Category "balance of responsibility" conceptualised as a continuum to enable inclusion of negative cases in theoretical model

(n.b. coloured font used to indicate codes from different participants)

Committing to being well

Committing to being well was constructed from several major codes in the data including: being proactive about mental health (i.e. monitoring mood changes or adhering to prescribed medication despite side effects), accepting help from others (e.g. attending a support group or contacting health professionals) and diverting suicide attempts.

> "I've learnt to accept help, I used not to, but I've learnt to accept help from this particular group, which is enormously important to me." (P9 – 306)

One participant James described how he had experienced several distressing, involuntary hospital admissions prior to getting his dog Isky and how he had been able to avoid further admissions through accepting responsibility for managing his own mental health.

> "I don't know what would happen if I went to hospital, what would happen to Isky poor girl, so I'm very responsible with the medication and what have you as I really don't want to lose her or have her go back into care as I love having her obviously, she's great company for me." (P1 – 401)

Two participants spoke very candidly and powerfully about their experiences of suicide and the impact of their dogs in potentially saving their lives and here I have included an excerpt from my interview with Julia (P9 – 389):

> Julia: "The more you think about it, the more you realise that that [the dog] really is the life-saving thread, it's interesting that I didn't even

think of the children, my two grown-up children who would have been devastated, far more than the dog, let's face it."

Researcher: "It's interesting that at the time, in the immediacy you were more able to see the dog, rather than to see the effect on your children."

Julia: "Yes because my children were, certainly one of my children was around at the time, so it wasn't as if they were out of sight, out of mind, they were there. And um but it was the dog."

Another participant, Alison, did not yet have her dog Remy when she made a very serious suicide attempt as a result of feeling totally overwhelmed by depression and grief. She described how having Remy would make her think differently in future.

"The last time I took an overdose it was definitely, definitely an impulse thing and like I say I've taken two overdoses in the past and both times it's been an impulse thing, um and I'm almost 99% sure I wouldn't have done it if I had Remy here.....I was in the house alone and I mean when would she have been found? I wouldn't have done that to her, I wouldn't no." (P8 – 760)

She also recognised that no-one can be certain how they will react in future situations, and as a mental health professional I reflected on this; whilst taking responsibility for Remy was very important to Alison and might cause her to hesitate before acting impulsively, services should never become complacent in collaboratively monitoring risk.

Reciprocity

Reciprocity comprises three subcategories: shifting focus towards recovery, putting the animal first and investing in the future; again these are interlinked.

Investing in the future

Committing to being well is mutually dependent on the subcategory investing in the future, as articulated by one participant who felt that being a dog owner and starting to accept her mental health difficulties were intertwined:

> "I have a lot of guilt around Thomas, you know "I'm not a good enough owner" and things like that, but I'm starting to think that he's there for a reason, like I needed the challenge, something I'm working out with him, because I didn't recognise myself as being depressed." (P4 – 97)

Additionally several participants talked about the hard work involved in looking after a puppy as a long-term investment. They were confident that the time and energy invested in their puppy would be far outweighed by the returns of having a well-adjusted adult dog in the future.

> "All dogs need a routine and I sort of take her out at 7 o'clock in the morning and take her out lunchtime at the same time, feed her at the same time, things like that, trips to train her, you know toilet train her and that first year of having a puppy is really, really hard. It's what you put in, you get out, you know, it's really, really difficult." (P8 – 40)

They discussed the decision to take on a companion animal and the long-term responsibility involved in owning a dog or cat that may be reliant on them for years to come. Participants also talked about this decision in terms of its impact on their mental health and the professionals working with them.

> "When we said we're getting a dog, at that time I had a community psychiatric nurse and I think she might have thought I was having a bit of a high but I don't think she realised, you know like it wasn't an impulsive decision but it had actually taken three years...I think my nurse realised in the end, you know when she saw we were very prepared for her and everything, she realised that it wasn't a rushed decision." (P10 – 450)

Interestingly one participant had made the decision not to have another cat, however she changed her mind when a stray cat 'adopted' her and has now happily owned this cat for over ten years.

> "I decided I wasn't going to have any more cats because the two that I had, had to be put to sleep for different reasons within the space of a few months and it was so distressing. I thought no more cats. Well there you are...that little tortoiseshell cat came into my life, just came into the garden." (P3 – 7)

She felt she had changed her mind in the context of her identity as a lifelong cat owner and this demonstrates how the overarching category identity acts as a 'short cut' in decision making, contrasting with Gina's experience above, as a first time dog owner.

Shifting focus towards recovery

Clustering several major codes generated this subcategory, which was helpful in explaining how reciprocity worked in practice.

Distracting

Both dog and cat owners, believed their animal functioned as a distraction in preventing them from unhelpfully focusing on their mental health difficulties.

> "You could just sit in the chair all day and think great I've done absolutely beeswax all today and then you start hating yourself which makes it all worse. You're going through in your head "I should have done this, I should have done that etc", which just makes it worse...So you think oh alright ok, even if you don't feel like it, so let's go and play ball...and then afterwards you think, I'm glad I did that, as opposed to sitting there thinking "no, not today" and then you start rumbling in your head." (P2 – 384)

> "So the physical thing of having to brush her and take her out and feed her, check that her toenails don't need cutting, you know perhaps pick up after her if she's had an accident, things like that. Cos she can be quite demanding as you've seen, she's up and she wants attention all the time, so it...interrupts your thought process a lot of the time." (P8 – 207)

Animals functioned as a physical distraction, for instance promoting activity as above, but were also able to distract owners from negative feelings by having a direct impact on their emotions.

> "Yeah she is quite funny, she gets these manic moments where she charges round. She runs up and down the lounge with a teddy and it's just so funny and it actually really makes me laugh and I just think all that is really good for me, especially when I'm really low." (P10 – 88)

However for one participant, feelings of guilt about her inability to meet her dog's need for stimulation could increase her tendency to ruminate and

therefore feel low in mood. This tendency increased as the gap between her expectations of ownership and the reality widened.

> "I think we're slightly mismatched, he would be a fantastic dog for a big family with lots of things happening and I actually feel a lot of guilt about that...You know, that I'm not really providing him with um, the excitement and stimulation that perhaps he deserves, or might want, but um anyway he's well looked after." (P4 – 76)

Improving physical health

Perhaps unsurprisingly dog owners were more likely to cite improved physical health, being outdoors and opportunities for social interaction as increasing wellbeing and therefore shifting their focus towards recovery.

> "It's nice in the countryside, you get to see all the wild flowers, all the people walking their dogs and it's a bit like going to the gym. I used to go to the gym, I didn't want to go, I got there I didn't enjoy it, I got back and then you feel good. With the dog I don't really want to go sometimes, I go and I actually enjoy it and I get back and I feel good...I actually enjoy it during where I used to find the gym quite boring when I was there." (P1 – 124)

Increasing social interaction

Whilst participants were enthusiastic about the positive impact of increased opportunities for social interaction, they emphasised how having a dog promoted 'manageable' interactions.

> "Sometimes if I'm low I feel quite pleased with myself that I've actually managed to get out, take her round the field, be sociable if I see another dog walker and actually when you feel low you lose, I find my self-esteem and my confidence goes down with it and sometimes I feel quite pleased that I've faced the challenge and I've done it, yeah I kind of always say it uplifts me." (P10 – 198)

Participants frequently described how social norms that applied to contact with other dog walkers enabled them to engage with other people in situations they would otherwise have found very challenging.

> "It's nice in the way that I can socialise, but not that closely, in that I can still come home and have my safety there, because I don't like people to get too close in that I, because I feel as if I'm going to let them down if I become ill. So I can socialise and have that, and have my own space as well." (P8 – 416)

The idea of an animal helping to 'regulate' interaction with other people applies to the category relating and will be explored further.

Putting the animal first

The final subcategory links closely to balance of responsibility and the category relating, as without this give and take it would be difficult to conceptualise these human-animal bonds as true relationships.

> "If I didn't have them [dogs and cats] then I'd almost become a potato couch if you like. Because I wouldn't get up and well, I'm not saying that I wouldn't, but it might have taken a longer period of time and if

you are sort of feeling the fear and having the animals there, they sort of look at you and say "come and play". Because you're almost doing it for them, but without realising it they're doing it for you." (P2 – 324)

As for balance of responsibility, participants appreciated support from family members intervening to meet the animal's needs when they were unable to.

"Yesterday I was really stiff with the arthritis and the weather was really bad...so I didn't take her out in the morning but my husband's really good, and it was raining and he still took her out and I thought ah, I was really grateful for that you know." (P10 – 554)

Relating

Communication

Without communication there can be no relationship and accordingly all participants discussed their experiences of communicating with their pets. Interestingly dog and cat owners were equally invested in communicating with their animals. Major codes included: owner understanding animal's communication, animal recognising (and responding to) communication from owner, expressing one's feelings to the animal, owner's emotional state impacting on animal and talking to others through the animal. These codes are clarified with examples from the data.

Understanding animals talking to you in their own language

"I mean the evidence that he is very sensitive is that he knows when Emily my daughter is coming home and then he comes and tells me.

And that's a change in his attitude, he will no longer be just flat out on his back with his legs in the air, he'll be alert and looking at me. He is definitely sensitive to her." (P9 – 526)

Animal recognising and responding to owner's emotions

"I know Millicent so well, that I can tell she can tell that I'm feeling things aren't as they should be. I'm sure it's not my imagination, and she does pick up on that. And I suppose it sounds a bit extreme but I don't like to see her upset because of me being upset, so I make an extra fuss of her and so we both benefit." (P3 – 214)

This idea of making an extra fuss of the cat when upset, in order to prevent the cat becoming distressed, which in turn makes Jan feel better herself demonstrates how the category relating can have an impact on reciprocity. Further evidence supports the idea that both cats and dogs are able to respond to changes in an owner's emotional state.

"Well, it's certainly true that an animal is incredibly intuitive. The two cats we've got now I know it to be a fact, they know when something's actually about to change, I notice how things alter in, in how they move around the house, they, they're intuitive towards it." (P5 – 97)

"Percy actually, I hesitate to say this but I do honestly think he can read thoughts a bit...there are people that believe that dogs can. I'm sceptical but um sometimes if I can't take him out yet because I've got other things to do and he just keeps on tracking me, I feel as if I have to close my mind to him. Um, I prepared to play along with that, but

it's certainly um it can be quite stressful to keep him out of my vision, sort of an internal feeling with him." (P9 – 505)

When I explored this further with Julia asking what she thought might be underlying his seeming ability to "read thoughts" she believed that it was in his interests to interpret her moods in the context of what they would likely mean for him and responded with:

"I don't know, I think we've probably spent a lot of time together (laughs) like an old couple." (P9 – 519)

Interestingly Arthur felt quite differently about his cats' ability to understand his feelings; however he did not believe their apparent lack of understanding detracted in any way from their positive impact on his wellbeing and their role as companions.

"I can talk to the cat, even though she can't talk back and I'm not sure she understands me, and I've got them trained, if I sit, she sits...I'm not sure they understand, but they're always there for you, you can turn to them, they make you happy and help you relax." (P7 – 95)

Expressing one's feelings to the animal

"Sometimes if I talk to the cat, perhaps it's like being in a confessional, I find I can address things that perhaps I wouldn't have done normally if I hadn't have had the cat to talk to." (P3 – 39)

"You know when you're very low and you might sit and be very maudlin...you don't do that if you've got the dog because you're so

> busy looking after the dog, it's like a distraction...Even if she'll sit there and I'll moan anyway to myself, and say Remy "look at me being silly" and she'll cock her head and I know she doesn't know what I'm saying but it's good she's there, she takes it all in." (P8 – 180)

Alison makes reference to both the communicative function of her dog i.e. "I'll moan anyway.....she takes it all in" and the role of practical care in distracting her from rumination, which succinctly demonstrates the triangle of mutual interaction between the three categories (relationship, reciprocity and responsibility) comprising the theory.

Feeling owner's mood may impact animal's mood

> "He um I feel looks for moods in me, so yes I think that if I'm very, very busy he'll just go and leave me...he goes "oh one of those moods is it" and off he goes, but I think equally it depends on the security you're offering the dog or child. If they've got the underlying security then they put up with the moods, but yes I think it's very, very difficult to tell which comes first, because you can be a bit low and then look at your dog and say well they're sitting and you're thinking if you looked at it objectively, well that's just what you're doing." (P9 – 953)

Here Julia offers a clear instance of how her mood is both recognised and responded to by her dog, as well as considering the impact of this interaction in terms of an attachment relationship. She also offers an explanation, hypothesising that the animal may simply be mirroring the owner's behaviour (e.g. sitting) and therefore appears to be experiencing a similar mood. Interestingly however, this does not seem to explain her dog's reaction (getting out of the way) to her behaviour (being busy), suggesting there is

more to this response (such as learning from past experience) than simple mirroring, an idea that is reflected in Nicole's comments.

> "If I'm really in an anxious state it makes him feel insecure and he starts to want to protect me...He gets quite guarded where other dogs are concerned, whereas if I'm feeling relaxed he'll be more [relaxed], you know dogs sometimes don't like each other and will have a little spat and it's more likely to happen if I'm feeling sad." (P4 – 195)

Detailed analysis of data comprising this code showed how conceptualising participants' responses as a continuum achieved the greatest explanatory effect. Participants' responses clustered along two dimensions: impact on the animal and taking comfort from the animal. Participants' relative positions could then be plotted along each of the axes.

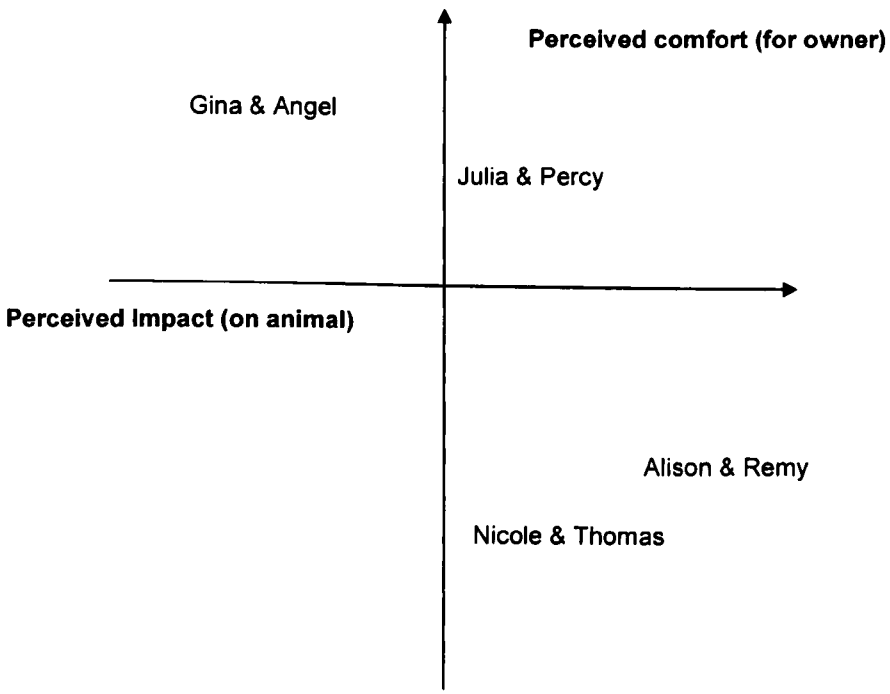


Figure 4 – Major code: Feeling owner's mood may impact animal's mood

Alison gave a further example of how, if she was feeling extremely low, she did not want Remy near her, and how Remy had learnt to seek out her husband, perhaps offering comfort to him instead.

> "It has an impact on her, she knows when I'm low and she won't come near me. Um I don't know if that's because she's frightened, she gets very upset if I'm upset, if I'm crying, she'll cry as well...she whimpers and George will reassure her that everything's alright. If I'm very, very low I suppose I'll initiate it by, I'll push her away and then George will take her away and he'll cuddle her and comfort her." (P8 – 658)

This contrasts markedly with Gina's view that the consequences of her depression are purely practical.

> "The only impact on her is probably when I'm low and she doesn't get out for a walk...I've never not wanted her by me, never turned away from her, so if anything I want her with me more." (P10 – 1027)

Talking to others through the animal

This was only mentioned explicitly by one participant who described how talking aloud ostensibly to the cat had enabled her to communicate with her father. During analysis I was drawn to the power of this idea in underlining the animal-owner-other triad and designated it as a major code despite its limited frequency in the data. This decision was validated later in the research process, as the idea of communicating to another person through the dog was raised independently by the service user focus group.

"I could communicate with my cat...and that helps me to put my own feelings out through the cat, and certainly when my father was alive...if I couldn't get through to him what I wanted to say, I talked to the cat. I'd say to the cat "oh funny Uncle Gordon" and I'd know damn well my father was listening! But I'd managed to get through via the cat what I wanted to say to my father." (P3 – 25)

Comfort

Unconditional acceptance

When participants talked about the unconditional acceptance they received from their animals they frequently referred to 'loyalty' and explained this in terms of the constancy of their animal's affection. The idea that, whatever may have gone wrong, their animals (unlike human friends or relatives) would always be pleased to see them was common to several participants.

"I mean on the positive side, the dog is tremendously devoted to the person, never questions what you do, so you get all that unconditional positive regard." (P4 – 49)

"It's lovely when you come home I mean the dogs meet you at the door, the cats are outside and sort of "oh goody, daddy's home" you know "we'll get something to eat". So I think definitely with animals they can always talk to you in their own language and make you understand them. It sounds cuckoo, but..." (P2 – 311)

Andrew associates his pleasure at being welcomed home with his understanding of his cat's communication and the reciprocity of their relationship, highlighting how comfort and communication are interlinked. Gina focuses on the constancy of her dog's affection, which she describes poignantly.

> "She's just there, loyal, whatever I feel she's just the same, consistent dog really...That's a nice reassuring feeling, I mean they always say dogs are really loyal whatever the person's like. If I had no arms and legs and I was in a wheelchair or whatever I'm sure she, now she's made that bond, I'm sure she'd still be really loyal, you know and sit by the side of the wheelchair." (P10 – 1072)

Source of affection

The affection their animals offered was equally important for both dog and cat owners. Julia articulated how powerful touch could be as a form of communication in meeting a basic need for connection (with both humans and animals), and therefore a source of comfort.

> "I may not talk to him but I do stroke him and I want to do more research into that, into touch...because I'm having to use it so much where I am now [working with people with severe learning disabilities], where there is no conversation and just that reaching out. I experienced it at my mother's death too, that her hand was the last thing I really had contact with...and I've found it very important in life, just another person's touch and as I say it works with animals as well." (P9 – 1099)

Participants frequently used the word "company" in responding to the question about how their role as a person with mental health difficulties and their identity as a pet owner co-existed or in illustrating how their animal had impacted on their recovery.

> "Well a cat's a bit of company and I always had mental health difficulties, more or less, off and on, all my life..." (P6 – 273)

And when I asked how the cat was company for her she responded:

> "Oh it's nice to hear her purr when she's pleased and she'll sit on my knee, and she leans right across and keeps your tummy warm, and she purrs and you can feel it vibrating and she leans." (P6 – 297)

This demonstrates how source of affection was used to construct the category comfort and therefore also linked to company. Another cat owner highlighted the comfort she received, whilst again linking the categories comfort and company.

> "Anxiety has been with me all my life; I don't think I shall ever recover from being an anxious person...as I've said to her more than once, she's just a furry comfort blanket and that's what she is really. I mean I'm really dreading you know when, for whatever reason Millicent is no longer around, but I'm just glad I've got her company and her friendship, simple as that." (P3 – 122)

I therefore thought carefully about whether company and comfort were best constructed as distinct categories or as a continuum of experience, as participants often raised the two in association. However, there was something so distinctive about the physical warmth and contact participants talked about, that I generated separate categories. Furthermore, whilst participants sometimes talked in terms of company, they actually seemed to be referring more to the comforting effect of stroking an animal.

"It's lovely to have the company really. I live by myself, and yeah just to have someone to sit next to in the evenings and stroke. I mean there's all sorts of things they say are therapeutic with stroking." (P1 – 56)

Empathy and attachment

Two participants described their experience of having pets in early childhood in relation to the loss of a parent and a chaotic home environment. Here it was the predictability, constancy and protection of the animal that invoked an attachment relationship.

"Once my father was going to hit me and the dog came out from under...a sort of cupboard thing and took my father's hand in his mouth, very nicely, and my father didn't hit me." (P6 – 36)

"I was never allowed to walk him, he was far too big, but round the house we were stuck together. What happened to him, happened to me, how he felt, I felt. If something frightened him, it was bound to frighten me, I was a child, so um you know we were mates...And the adult in me says "what chaos were you living in that you needed that?"...and that's why it's only looking back down the years, so many years now, that I realise just what an anchor the dog was." (P9 – 424)

Interestingly the focus group also talked about attachment, with Winnicott's idea of transitional objects suggested as a theoretical explanation for the comfort pets offer (Winnicott, 1971). The importance of empathy and trust in developing reciprocal relationships (often characterised by mutual attachment) was also raised by participants in the context of current experiences.

"Like any animal really, they've got to build a relationship with you and then trust you, I think that's really important. I mean it's like a horse, if you don't trust the horse, make a bond with them, they'll sort of say right I'm ten times bigger than you, so I'm going to take charge; you can't control it and you're off the saddle." (P2 – 300)

"When we've been on holiday and the boys have looked after her, she's very much stayed on my bed, on my side and she gets really depressed, she looks at the boys with really sad eyes. She really does feel it, so then I feel real, all these feelings of guilt which are really hard, but I know the boys look after her, because everyone adores her and she loves all the family but if we're sitting down it would be me, like now, she'll sit with me, mummy's baby." (P10 – 139)

Company

Companionship

As discussed above company was closely linked to the subcategory comfort and strikingly all ten participants talked about companionship as an important aspect of their relationship.

"They're very, very shy animals, very good relationships with us but with anybody else it's very difficult for them. But as we got them really only to be a pleasure to my wife and I, it's perfect that that's the way it is." (P5 – 11)

"Just getting back into the real world, getting into normal life I suppose, it does help; it's very nice to have the company and to have someone to talk to, although she doesn't answer back very much!" (P1 – 459)

This illustrates the links between company, recovery and communication, offering further evidence for the triangular construction underpinning the model. Whilst Gina relates companionship to reciprocity:

> "When I feel low I don't often feel like talking to people, I just want to be on my own and that's the way I deal with it. Obviously I've got family around me, but sometimes I just sort of go into myself a little bit and she'll just still be there, she's still a steady companion whatever you're feeling." (P10 – 114)

Improving relationships

Moving onto discuss how a companion animal could improve relationships within a family, a theme from both participant interviews and the service user focus group, Alison talked about how her puppy had enabled her to relate her grandchildren, something she had previously found difficult when depressed.

> "My grandchildren especially are really, really fond of her so when they come it helps me to look after them, because my grandchildren are quite a handful...With having the dog they've got involved more with Remy and they've looked after her and helped me. They've come with me when we've taken her for a walk, so because very often I don't know what to do with the grandchildren, you know if I'm feeling a bit low, she's helping in that way as well." (P8 – 586)

For Alison it was the practical aspect of having a dog that enabled her to relate to her grandchildren, for example through enjoying a shared activity such as dog walking. However as discussed earlier an animal may promote communication between people and therefore improve relationships within the family through facilitating dialogue.

Pets as family

The idea of pets as family interestingly applied to both single owners and those who lived within families. Therefore this demonstrates that animals can be an addition to an existing family unit as well as offering a substitute family in the absence of other people.

> "I'm envious I suppose, I just wish I was part of a good, you know, a supportive family but I don't have a family so there isn't anyone...I said to Millicent "Oh God, this is a bit pathetic isn't it, poor old Jan, this is me an old maid on her own and the cat!" (laughs) and that's a family and then I think "oh snap out of it for goodness sake!"...I mean families come in all shapes and sizes, two legs, four legs." (P3 – 147)

> "I mean my daughter actually lives with me and um yes we both are aware of what we're doing, we play the game that he's part of the family...He's a fully paid up member, if you know what I mean, as far as I'm concerned because he just takes a different form. There's a personality there that I love and that responds to me and so he's a person in some senses, he's a person he just happens to have fur." (P9 – 462)

As Julia's description illustrates, participants recognised distinct personalities in their animals and it may be that this ability to relate to a sentient being led participants to see pets as part of their family system.

Recovery

Recovery and identity were conceptualised as two overarching themes that exerted influence on the triangular relationship between responsibility,

reciprocity and relating. The role of companion animals in recovery was strongly linked to reciprocity and responsibility i.e. committing to being well.

> "For a year I literally didn't get up 'til 2 o'clock in the afternoon and I was very poorly...I mean I was just so low, that it was difficult to physically break that and having her [dog] has forced me out of that and I feel much better for it now. I mean in that time I didn't have any voluntary jobs and now I have three and so, I'm well on the road to recovery." (P1 – 75)

> "So I'm in recovery managing my illness, yeah and there has been a recovery journey and I really think she [dog] has had a big part in the last three years of making me feel responsible and trying to keep me out of hospital you know." (P10 – 826)

Negative cases highlighted participants who did not feel having a pet influenced their mental health when they were for example very depressed, however as their recovery progressed they became more able to engage with their animal again.

> "I was ill when we had [previous cat] and I was really somewhat dismissive of the animal and um he was there and I was aware of him being there but I think probably that my wife was taking the more major responsibility...I think when I was seriously ill with depression, he didn't really lift me very much. But as I pulled out over it, as I came out of it of course it meant he assumed a bigger part in my life, like before I became ill." (P5 – 82)

Identity

Identity was conceptualised as an overarching category as it too was a theme that pervaded the majority of interviews. For example in many cases participants had grown up with pets, self-identified as 'animal lovers' or had owned an almost continual succession of animals during their lives. For these participants, life without at least one companion animal was difficult to imagine and I believe that this contributed to the likelihood of people perceiving their animal as part of their recovery.

> "I couldn't do it now, it's too expensive but um, my family on a very small income had a menagerie. And that's where you learnt to care, particularly if you're an only child." (P9 – 61)

> "I had pets ever since I've known. I was bought up [abroad] so we had a horse and dogs and little reptiles that crawl around your garden, not as pets, but I've always had pets of one form or another." (P2 – 70)

> "I've had lots of pets, mice, guinea pigs, gerbils, pretty much everything!" (P7 – 22)

However, it is important to stress that some participants were new to pet ownership and this in itself did not appear to impact their perception of the animal's role in their recovery. In several cases, since becoming pet owners, despite the challenges, they could not imagine life without their animals.

> "It's actually quite hard to imagine not having the dog now." (P4 – 25)

"You obviously have love for your animal and I'd hear people say "you know if anything happened to my dog I don't know what I'd do" and I now understand when people say that. I used to think how can they say that about an animal but now I know, you know that feeling. So all I can say if I could put it in one word, it's just one big pleasure." (P10 – 1103)

BLANK PAGE
IN
ORIGINAL

Discussion

As the recovery movement gains momentum and mental health services are increasingly organised around the promotion of personal recovery it seemed apt to consider how relationships with companion animals may enable service users to self-manage their mental health difficulties. Therefore the aim of this research was to explore what role, if any, companion animals can play in recovery from serious mental health difficulties. A grounded theory methodology generated a middle range theory to explain how companion animals may encourage and support recovery, and so this project has begun to address one of the key gaps in current understanding of human-animal interactions (e.g. Chur-Hansen *et al.*, 2010). The theory comprises five core categories constructed following in-depth interviews with service users. These categories are: relationship, responsibility, reciprocity, recovery and identity.

This chapter will discuss the grounded theory of the role of companion animals in recovery in the context of existing literature and theoretical understanding. The implications of the findings, both for service users and mental health professionals, will be considered along with potential limitations of the current work as well as recommendations for future research.

Findings in the context of existing literature

Literature in the introduction highlighted the lack of consensus about possible physical and psychological benefits of owning and caring for companion animals (e.g. Wells, 2011). Quantitative research has found a positive, neutral and even negative impact of interactions with companion animals (Chur-Hansen et al., 2010), even within the same population, an example of this being research with older adults (e.g. Siegal, 1990; Parslow *et al.*, 2005). In many cases where a positive impact has been reported it has been difficult to interpret these quantitative results with confidence due to methodological weaknesses (i.e. cross-sectional designs) resulting in calls for further

qualitative research to explore the subjective meanings of human-animal interactions (e.g. Walsh, 2009a). Of particular note is the scarcity of research with people who have lived experience of mental health difficulties, which I found somewhat surprising as reports of animals being used therapeutically with this population date back to the late 18th century (Tuke, 1813; in Slade, 2009).

Some of the factors comprising the grounded theory, for example animals as a source of company or as increasing opportunities for social interaction, are reflected in earlier findings (Antonacopoulos & Pychyl, 2010; McNicholas & Collis, 2000). However, new themes that had not as yet been acknowledged in the literature were also identified, for instance the importance of reciprocity in developing a recovery focus. Each of the five major categories comprising the theory will now be contextualised with reference to the current literature.

Responsibility

The category responsibility was constructed from three related subcategories: practical care, balance of responsibility and committing to staying well.

Practical care

Participants described how taking responsibility for the care of a pet enabled them to maintain their own routines, gaining a sense of achievement and therefore progress in their recovery. This is a similar finding to that of qualitative research with service users in the USA, where taking responsibility for a pet was reported to increase feelings of self-efficacy and empower people to make decisions, with one service user crediting his sense of responsibility for his pets with regaining his desire to recover (Wisdom *et al.*, 2009). Furthermore, researchers interviewing service users living in a supported housing project who were keeping pets in contravention of the

housing project's stated 'no pets' policy, identified responsibility along with the importance of maintaining a regular daily routine as a major theme, even though the pets were being kept illicitly (Hunt & Stein, 2007).

Balance of responsibility

Interestingly, and perhaps unsurprisingly, taking responsibility for the care of a companion animal was not always experienced as positive by participants in this research. This led me to conceptualise responsibility as a continuum with multiple contingencies (i.e. sharing responsibility with family, current difficulties with mental health and other caring responsibilities) influencing responses (i.e. whether responsibility was perceived as beneficial). Whilst the negative aspects of responsibility have been alluded to in the literature, to my knowledge, it has not been conceptualised as a continuum before. During data analysis I found that organising participant responses in this way had an explanatory function in determining how a service user might experience responsibility. Examples where potentially negative aspects of responsibility have been considered include: service users becoming overwhelmed by their pets' needs (Wisdom *et al.*, 2009) and where conflicts between caring for the pet and following health related advice arise, such as in the management of allergies (McNicholas *et al.*, 2005). Additionally in a quantitative study of British Catholic clergy the increase in emotional exhaustion reported by priests who owned dogs (a finding totally unanticipated by the initial hypothesis) was suggested to occur as a result of the incompatibility of adequately looking after a dog whilst maintaining an emotionally demanding, full-time career, which often necessitated being on-call (Francis *et al.*, 2007). Whilst none of my participants worked full-time, several worked part-time in paid or voluntary roles and did express concern about managing the demands of work alongside the difficulty in leaving their dogs alone for extended periods.

Committing to staying well

Both dog and cat owners discussed the influence of their pets in encouraging them to take care of themselves and their mental health in particular, with examples including adherence to medication and very significantly, averting suicidal behaviour. The idea of animals saving lives in this way is not a new one (Hafen *et al.*, 2007), with family therapists who worked alongside veterinarians in a small animal practice reporting that bonds with pets could provide meaning in people's lives and therefore were a protective factor in decreasing the risk of suicide attempts in veterinary clients expressing suicidal ideation.

Reciprocity

Three subcategories: shifting focus towards recovery, putting the animal first and investing in the future were used to co-construct reciprocity, with participants emphasising how much they gained from their relationships with pets, with one saying of dog ownership "if I could put it in one word, it's just one big pleasure". This is consistent with previous qualitative research with mental health service users that found pets were perceived as "giving more and expecting less than human companions" (Wisdom *et al.*, 2009, pp.433).

Investing in the future

Participants talked about how carefully they had considered the decision to acquire a pet, and how taking on a puppy in particular was a long-term project, with the time and effort invested being worthwhile to gain a well-adjusted adult dog. This idea of pets enabling service users to focus on a longer-term future appears to be an original theme with no similar findings in the current literature. Interestingly, it seems that sometimes a service user's decision to take on a pet has been viewed with scepticism by mental health professionals worried for example that this might represent a "high" mental state in bipolar disorder. Therefore mental health professionals may also

need support to understand a service user's rationale for acquiring a new pet and motivational interviewing techniques (Rollnick & Miller, 1995) could offer a helpful framework to explore decision making with service users.

Shifting focus towards recovery

Reciprocity in action: by promoting a recovery focus, companion animals positively impacted their owners' mental health. As in the current study, existing research has also shown the role animals can play in distracting from anxiety and other mental health symptoms at both a practical and emotional level, by increasing an owner's ability to engage in the wider environment (Walsh, 2009a). However, in a negative case, one participant found that interacting with her dog actually increased her focus on difficult feelings (e.g. guilt) and felt that this was due to a "mismatch" in their relationship. Quantitative research utilising questionnaires to explore a relatively novel aspect of human-animal relationships, compatibility or the 'fit' between an owner and their pet, may offer an explanation, as multiple regression analyses showed that people who felt they were more compatible with their pets reported improved mental health and fewer physical symptoms (Budge *et al.*, 1998).

Participants frequently cited the benefits of increased social interaction and physical exercise as encouraging them to focus on their recovery journey. The role of physical exercise in promoting mental health is well established (including recent endorsement by the Royal College of Psychiatrists, 2009). The influence of animals in increasing social interaction has been proven experimentally with one experiment showing that, even where a dog was trained not to solicit attention from passers-by, significantly more approaches were made by strangers (McNicholas & Collis, 2000). This effect has been replicated in physically disabled populations who were approached significantly more often when accompanied by their assistance dogs (Hart *et al.*, 1987). However less emphasis has been placed on the nature of these

interactions, with participants in this study acknowledging how important it was that social norms applied to dog walking acted to regulate the interactions, therefore giving participants confidence to engage with others in a way they had previously found difficult, which was a novel finding.

Putting the animal first

The concept of facing one's own challenges in order to meet the animals' needs was raised by several participants, particularly in relation to going out into the community. This echoes the findings of Knight & Edward's (2008) focus groups with dog owners who reported that whilst they did not always want to leave the house (for a variety of reasons), they were motivated to do so by their dog's need for exercise and once on a walk they invariably felt better, both physically and psychologically.

Relating

Communication, comfort and company were identified as subcategories in the data that could be helpfully understood in terms of the relationship between a person and their pet.

Communication

Participants explained how communication with their pets was a three-way process involving them, the animal and often an 'other', which could be a person or another animal. Some of the types or functions of communication described have been recognised by previous research as follows: confiding in the pet (Hunt & Stein, 2007) and as a form of non-judgemental social support even where other people are available (Allen, 1995). There are also anecdotal reports in the literature of one major code, using the animal as a means to improve communication with other people, both in therapy sessions (e.g. Imber-Black, 2009) and within families (Walsh, 2009a),

although further work is need to explore the mechanisms and contexts involved.

Another important major code: feeling owner's mood may impact animal's mood was conceptualised as a grid with owner-pet dyads varying on two dimensions, perceived comfort (for owner) and perceived impact (on animal). This enabled me to incorporate all related cases in the data and had parallels with attachment theory, where individuals typically have a developed attachment style and therefore means of regulating affect in distressing situations (Bartholomew & Horowitz, 1991; Bowlby, 1982). The four adult attachment styles: secure, anxious–preoccupied, dismissive–avoidant, and fearful–avoidant are therefore hypothesised to explain differences between owners in the level of comfort they were able to gain through interactions with their pets. It could be that owners with a secure attachment style are able to receive emotional support from their relationships with pets (and also with people), whereas owners with a more ambivalent style of attachment may experience conflicted feelings about whether they are prepared to seek comfort from others (humans and pets). The idea of how an owner's attachment style may influence their relationships with pets has never, to my knowledge, been discussed in the literature before. This would therefore seem a very important finding in determining who (and in what circumstances) may be able to attain psychological benefits from companion animals. Interestingly, the owners who reported receiving immense comfort from their animals in times of distress were split in their views about whether their emotional distress and affect regulation strategies had an impact on the animal. Therefore this is an area where further research may present real opportunities to increase our understanding of human-animal relationships.

An owner's ability to recognise the impact of their mood on a pet depends on a mutual understanding of emotional state. Dogs and cats communicate using a complex system of visual cues, body postures and vocalisation (e.g.

Bradshaw & Nott 1995; in Serpell, 1995), which owners are often able to interpret. Evidence that dogs are able to understand and respond to owner's communication comes from research into family systems, which showed that pets were "tuned into" both the expression of emotion by individuals as well as systemic difficulties such as conflict with the family (Cain, 1983 in Walsh 2009b, pp.485), frequently "acting out" distress through their behaviour in a similar way to children experiencing conflict.

Comfort

Research dating back to the early 1980s found that dog owners asked to use adjectives to describe their dog frequently talked about their relationships with their pets in terms of acceptance/trust and love/friendship (Salmon & Salmon, 1983; in Serpell, 1995). Over the last 30 years, the relationships people form with their companion animals have been the focus of a large proportion of the human-animal interaction research; however there is still considerable debate about the role of attachment in bonds with pets. A growing consensus that people do form attachment bonds with their pets seems to be emerging; characterised by mutual care giving, security and grief on becoming separated (Archer, 1997; Archer & Winchester, 2004). However, uncertainty remains about the correlation between strength of attachment and potential benefits for an owner's health, as well as existing measures of human-animal attachment, such as quality time spent with the pet (Chur-Hansen *et al.*, 2009; Peacock *et al.*, 2012). In this work, participants talked candidly about their attachment relationships with their dogs and cats, for example how when anxious they could turn to their pets for comfort or how they enjoyed having 'someone' to love and look after. They also discussed how their pets increased their feelings of both emotional and practical security, which was consistent with other research (Wood *et al.*, 2007) and found to be of most benefit at times of uncertainty (Cain, 1985 in Walsh, 2009b). They also talked about the reassuring effect of giving and receiving physical affection, such as stroking, which has found to be a

reciprocal benefit with a resultant decrease in physiological arousal for both the owner and animal (Lynch & McCarthy, 1969).

Company

The major codes companionship, improving relationships with family and seeing animals as part of the family were brought together to construct the category company. Strikingly companionship was the only major code discussed in detail by all participants and I believe this demonstrates the strength of feeling that supports the idea of pets as a source of company for people, an idea that also predominates in the literature (e.g. McNicholas *et al.*, 2005). At times of sadness and distress one or two participants commented that they preferred the company of their animal to that of family members, possibly as they make fewer emotional demands than other people can, a finding reflected in a study of women who had recently been widowed (Allen, 1995) with the women describing how their dogs allowed them to be themselves and to set aside the expectations of friends and family.

Whilst the function of animals in improving communication within families was discussed earlier, their apparent function in improving personal relationships was also raised by participants. One example involved a puppy providing a mutual interest and source of shared activities (e.g. playing, grooming and walking) between a grandmother (participant) and her primary school-aged grandchildren. Interestingly, this change to the relationship was perceived by both the grandmother, who felt more confident in finding pleasurable activities to share with the children, and therefore more able to spend longer periods of time with them, and also by the grandchildren who reportedly now looked forward to spending time with their grandmother (and the puppy). This is a very underdeveloped area in the literature; with only one study describing pets as the "glue" that plays a part in holding a family together

(Cain, 1983; in Walsh 2009b, pp.483), therefore it presents a promising area for future research.

Finally, pets were considered to be valued members of the family by the majority of participants with one eloquently stating that "families come in all shapes and sizes", by which I anticipated she was referring for example to step-families, same-sex couples, however she went on to finish her sentence with "two legs, four legs" which I thought was a clear illustration of how pets can be embedded in families. Again this finding seemed relevant for both single owners and those living with (human) families. In a quantitative survey of women from ethnic minority backgrounds Risley-Curtis *et al.* (2006) found that the overwhelming majority believed their pets to be family members and I believe this is also evidenced by the ever increasing amount of money spent on pet food, leisure and healthcare industries (e.g. Wells, 2009).

Recovery

Recovery and identity were conceptualised as two overarching themes or theoretical constructs that influenced interactions within the triangular relationship between responsibility, reciprocity and relationship. Participants described the decision-making process around acquiring a pet as a catalyst in their recovery journey. Some felt that they owed some of the credit for progress they had made to their dog or cat. Again there is very little written about companion animal ownership in the context of recovery, despite advocates of personal recovery stressing the importance of "play, pleasure and other positive life events" (Davidson *et al.*, 2006), incidentally all of which pets can offer. One study of a weekly animal-assisted therapy programme with inpatients with a diagnosis of schizophrenia found a significant improvement in activities of daily living as assessed by the Independent Living Skills Survey (Kovacs *et al.*, 2004). Perhaps more importantly they found these improvements were maintained outside of the therapy sessions and that patients were able to persist with the programme for its whole

duration in a way that they had not been expected to due to their lack of engagement with other activities.

Identity

Many of the participants described themselves as 'animal lovers'. For some, animals had been a part of their whole lives, with one even bringing in a photo of her as a baby sitting in a pram with the family's dog (who was a puppy at the time). This was something I could personally identify with having had at least one pet almost continuously since the age of 4 years old. I think this is key to improving understanding of who may be able to gain both physical and psychological benefits from companion animals in considering the balance of responsibility outlined earlier. Animals are frequently messy and frustratingly disobedient, requiring a huge commitment from owners in terms of both time and money, therefore it seems logical that self-confessed animal lovers will be able to see through these challenges in order to access benefits in a way that others may not be able to. However, it is also important to emphasise that some participants were relatively new to pet ownership and, whilst the decision to get a pet might not have been as automatic as for the 'animal lovers', it was difficult to distinguish between the two groups in terms of the benefits of ownership they subsequently reported.

The idea of identity is important in recovery terms with Slade (2009) acknowledging that recovery involves relationships with oneself, with others and also with the wider environment. He suggests that relationships can offer opportunities for identities other than the "mental patient" to develop, and this was clearly reported by participants who found sanctuary in the role of 'dog owner' for example, in their interactions with friends made through dog walking. In several cases participants did not tell these new friends about their mental health difficulties as they valued being treated "just like everybody else". Slade (2009) also recognises the importance of external relationships with others and includes relationships with pets in this category,

giving an example of a hospitalised patient's desire to return home to look after their pet cat as a turning point in their recovery.

Evaluation

Representativeness of participants

The decision to focus only on service users who owned either dogs or cats limited the scope of the research in considering what role other species of companion animals may play in recovery, with existing research divided between that considering only dogs and cats (e.g. Archer, 1997) and that considering a wide range of species including mammals, birds, reptiles and fish (e.g. Wisdom *et al.*, 2009).

Younger adults were under-represented in my study and it would be interesting to see whether this is the case in the pet-owning population as a whole (i.e. younger people may be more likely to work full-time and therefore be reluctant to take on the responsibility of a pet) or if this is an artefact of recruitment through support groups (i.e. do younger people access support for mental health difficulties through alternative sources such as social networking websites). People from ethnic minority backgrounds were also under-represented and I found it difficult to determine whether this was the case across the pet owning population as a whole or whether this again could be an artefact of recruitment (e.g. geographical area).

Measuring attachment

Participants' attachment style was not measured therefore findings about the role of attachment in determining the interaction between pet ownership and comfort are speculative. Participants' attachment to their pets was also not measured formally, however it remains to be seen how helpful this may have

been due to the ongoing debate about what constitutes human-animal attachment and how best to measure it.

Influence of researcher

Whilst acknowledging that the researcher is integral to the process and findings of qualitative research (e.g. Charmaz, 2006), transparency at all stages is necessary to ensure that this influence does not unduly bias findings (Yardley, 2000). Measures taken to ensure transparency included: being interviewed by a colleague about my preconceptions before starting to interview participants, keeping a reflective diary throughout, submitting excerpts of transcripts for coding by peer-researchers to allow comparison with examples of my coding and carrying out a detailed search of existing literature only after the grounded theory had been developed from the data.

Choice of methodology

The grounded theory constructed was robust enough to accommodate the overwhelming majority of participants' responses and therefore, whilst data saturation cannot be claimed, theoretical saturation can be supported. Furthermore, whilst other qualitative methodologies (e.g. interpretative phenomenological analysis) may have enabled more in-depth exploration of how participants' made sense of their experiences they would have not enabled the generation of theory in the same way as grounded theory. I was also aware that there are limitations of using interviews as a means of data collection. For instance there is a risk of participants giving responses they believe agree with the researcher's stance, and it is important to consider the possibility of this as participants frequently asked whether I had pets (Charmaz, 2006).

Implications for practice

Implications of the grounded theory

Towards the end of the project, in order to assess the credibility of the research, I presented the grounded theory of the role of companion animals in recovery to mental health workers at a branch of a national charity where I had previously recruited participants. The following five implications for practice arose from the subsequent discussion of the model:

1. The importance of services acknowledging the complexity of people's relationships with their companion animals and the impact pets can play in a service user's recovery. Accordingly the need for services to embed policies and procedures for use in situations when a service user might not be able to look after a pet themselves (e.g. hospitalisation).
2. For services to think about contact with animals in a broader sense than pet ownership (i.e. visiting Pets as Therapy dogs, opportunities for horse riding, visits to animal sanctuaries, dog walking included as part of 'healthy walking' initiatives) for people who do not want to, or would not be able to manage, owning and caring for a pet themselves.
3. As mental health professionals, to explore with people whether they would like to own a pet and how services may be able to support them (i.e. by increasing understanding of pet care responsibilities, supporting a service user to make contact with animal rescue charities, or in accessing any available financial support).
4. Where service users have expressed interest in animals, mental health professionals should consider how this can be used occupationally in a person's recovery i.e. seeking voluntary work with animal charities (e.g. dog walking at rescue kennels) or attending further education such as animal care courses. This would have an additional benefit of providing wider socialisation opportunities outside those offered by mental health services.
5. An awareness of the challenges for services in implementing change as the onus will be on existing staff to deliver change, within existing

budgets. In the current economic climate this is likely to be the case across all sectors. However, it will be particularly pertinent for charities where there are many competing demands for limited available funding. Therefore there is a need for further empirical work about the role of pet ownership in recovery and more widespread awareness of findings in the field of mental health.

Implications for future research

In considering the implications for research, I believe this project has demonstrated the need for further exploration of the concept of attachment in the context of human-animal relationships. For instance, is it appropriate to transpose established human models of attachment or is an entirely new framework needed in thinking about these relationships. Currently there is no consensus on how human-animal attachment should be measured, with existing measures (such as amount of owner's time spent with their pet) being unsophisticated and unvalidated. A potential application of this work would be in considering how our knowledge of the attachments owners form with their pets can be used to increase our understanding of attachment relationships in people where patterns of attachment may be atypical, for example the relationship between primary caregivers and children with autistic spectrum disorder (ASD).

BLANK PAGE
IN
ORIGINAL

References

Ainsworth, M.D.S. (1989). Attachments beyond infancy. *The American Psychologist, 44*, 709–716.

Allen, K.M., Blascovich, J., Tomaka, J. & Kelsey, R.M. (1991). Presence of human friends and pets dogs as moderators of autonomic responses to stress in women [Electronic version]. *Journal of Personality and Social Psychology, 61(4)*, 582–589

Allen, K.M. (1995). Coping with life changes & transitions: The role of pets [Electronic version]. *Interactions, 13(3)*, 5–8.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders (4th Edn.)*. Washington, DC: Author.

Anthony, W.A. (1993). Recovery from mental illness: the guiding vision of the mental health system in the 1990s. *Innovations and Research, 2*, 17–24.

Antonacopoulos, D. & Pychyl, T.A. (2010). Examining the role of pet ownership, human social support, pet attachment in psychological health of individuals living alone [Electronic version]. *Anthrozoös, 23*, 37–54.

Archer, J. (1997). Why do people love their pets? [Electronic version]. *Evolution of human behaviour, 18*, 237–259.

Archer, J. & Winchester, J. (1994). Bereavement following death of a pet [Electronic version]. *British Journal of Psychology, 85*, 259–271.

Ascione, F. & Shapiro, K. (2009). People and animals, kindness & cruelty: Research directions and policy implications [Electronic version]. *Journal of Social Issues, 65(3)*, 569–587.

Bartholomew, K. & Horowitz, L.M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology, 61(2)*, 226–244.

Budge, R.C., Spicer, J., Jones, B. & St.George, R. (1998). Health correlates of compatibility and attachment in human-companion animal relationships [Electronic version]. *Society and Animals, 6(3)*, 219–234

Bowlby, J. (1982). *Attachment and loss: Vol. 1 Attachment* (2nd Edn.) Harmondsworth, UK: Penguin.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis.* London: Sage.

Cohen, S. & Hoberman, H.M. (1983). Positive events and social supports as buffers of lifechange stress. *Journal of Applied Social Psychology, 13*, 99–125.

Cohen, S.P. (2002). Can pets function as family members? [Electronic version]. *Western Journal of Nursing Research, 24*, 621–638.

Chur-Hansen, A., Russell Winefield, H. & Beckwith, M. (2009). Companion animals for elderly women: The importance of attachment [Electronic version]. *Qualitative Research in Psychology, 6*, 281–293.

Chur-Hansen, A., Stern, C. & Winefield, H. (2010). Gaps in the evidence about companion animals and human health: some suggestions for progress [Electronic version]. *International Journal of Evidence-Based Healthcare, 8*, 140–146.

Collis, G.M. & McNicholas, J. (1998). A theoretical basis for health benefits of pet ownership. In C.C. Wilson & D.C. Turner (Eds.), *Companion animals in human health*. Thousand Oaks, CA: Sage.

Davidson, L., Shahar, G., Staeheli Lawless, M., Sells, D. & Tondora, J. (2006). Play, pleasure and other positive life events: "Non-specific" factors in recovery from mental illness? [Electronic version]. *Psychiatry, 69(2)*, 151–163.

Elliot, R., Fischer, C.T. & Rennie, D.L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38,* 215–229.

Fairman, S. & Huebner, R. (2001). Service dogs: A compensatory resource to improve function [Electronic version]. *Occupational Therapy in Health Care, 13*, 41–52.

Francis, L.J., Turton, D.W. & Louden, S.H. (2007). Dogs, cats and Catholic parochial clergy in England and Wales: Exploring the relationship between companion animals and work-related psychological health [Electronic version]. *Mental Health, Religion & Culture, 10(1)*, 47–60.

Friedmann, E. Honori, A., Lynch, J.J. & Thomas, S.A. (1980). Animal companions and one year survival of patients after discharge from coronary care unit [Electronic version]. *Public Health Reports, 95(4)*, 307–312.

Friedmann, E. & Thomas, S.A. (1995). Pet ownership, social support and one-year survival after acute myocardial infarction in the Cardiac Arrhythmia Suppression Trial (CAST) [Electronic version]. *American Journal of Cardiology, 76*, 1213–1217.

Garrity, T.F., Stallones, L., Marx, M.B. & Johnson, T.P. (1989). Pet ownership and attachment as supportive factors in the health of the elderly. *Anthrozoös, 3*, 35–44.

Gosse, G.H. & Barnes, M.J. (1994). Human grief resulting from the death of a pet. *Anthrozoös, 7*, 103–112.

Guest, C.M., Collis, G.M. & McNicholas, J. (2006). Hearing dogs: A longitudinal study of social and psychological effects on deaf and hard-of-hearing recipients [Electronic version]. *Journal of Deaf Studies and Deaf Education, 11*, 252–261.

Hafen, M., Rush, B., Reisbig, A., McDaniel, K. & White, M. (2007). The role of family therapists in veterinary medicine: Opportunities for clinical services, education and research [Electronic version]. *Journal of Marital and Family Therapy, 33(2)*, 165–176.

Hart, L.A., Hart, B.L. & Bergin, B. (1987). Socialising effects of service dogs for people with disabilities. *Anthrozoös, 1*, 41–44.

Hunt, M.G. & Stein, C.H. (2007). Who let the dogs in? A pets policy for a supported housing organisation [Electronic version]. *American Journal of Psychiatric Rehabilitation, 10*, 163–183.

Imber-Black, E. (2009). Snuggles, my co-therapist and other animal tales in life and therapy [Electronic version]. *Family Process, 48(4)*, 459–461.

Knight, S. & Edwards, V. (2008). In the company of wolves: The physical, social and psychological benefits of dog ownership [Electronic version]. *Journal of Aging and Health, 20(4)*, 437–455.

Kovács, Z., Kis, R., Rózsa, S. & Rózsa, L. (2004). Animal-assisted therapy for middle-aged schizophrenic patients living in a social institution: A pilot study [Electronic version]. *Clinical Rehabilitation, 18*, 483–486.

Kurdek, L. (2008). Pet dogs as attachment figures [Electronic version]. Journal *of Personal and Social Relationships, 25(2)*, 247–266.

Lane, D.R., McNicholas, J. & Collis, G.M. (1998). Dogs for the disabled: Benefits for the recipient and welfare of the dog [Electronic version]. *Applied Animal Behaviour Science*, *59*, 49–60.

Loveys, K. (2010, 2 August). Why petting your dog is the 'best form of stress release'. *Mail Online*. http://www.dailymail.co.uk/news/article-1299743/Why-petting-dog-best-form-stress-release.html#ixzz1w5jrDLHS Accessed 20 May 2012.

Lynch, J.J. & McCarthy, J.F. (1969). Social responding in dogs: Heart rate changes to a person. *Psychophysiology*, *5*, 389–393.

Margolies, L. (1999). The long good-bye: Women, companion animals and maternal loss [Electronic version]. *Clinical Social Work Journal*, *27*, 289–304.

McNicholas, J. & Collis, G.M. (2000). Dogs as catalysts for social interactions: Robustness of the effect [Electronic version]. *British Journal of Psychology*, *91*, 61–70.

McNicholas, J., Gilbey, A., Rennie, A., Ahmedzai, S., Dono, J., & Ormerod, E. (2005). Pet ownership and human health: A brief review of evidence and issues [Electronic version]. *British Medical Journal*, *331*, 1252–1254.

Morley, C. & Fook, J. (2005). The importance of pet loss and some implications for services [Electronic version]. *Mortality*, *10(2)*, 127–143.

Netting, F.E., Wilson, C.C. & New, J.C. (1987). The human-animal bond: Implications for practice [Electronic version]. *Social Work, 32(1)*, 60–64.

Parslow, R.A., Jorm, A.F., Christensen, H., Rodgers, B. & Jacomb, P. (2005). Pet ownership and health in older adults: Findings from a survey of 2551 community-based Australians aged 60–64 [Electronic version]. *Gerontology, 51*, 40–47.

Peacock, J., Chur-Hansen, A. & Winefield, H. (2012). Mental health implications of human attachment to companion animals [Electronic version]. *Journal of Clinical Psychology, 68(3)*, 292–303.

Phelan, M., Stradins, L. & Morrison, S. (2001). Physical health of people with severe mental illness [Electronic version]. *British Medical Journal, 322*, 443.

Pidgeon, N. & Henwood, K. (1997). Using grounded theory in psychological research. In N. Hayes (Ed.) *Doing qualitative analysis in psychology*. East Sussex: Psychology Press Ltd.

Podrazik, D., Shackford, S., Becker, L., & Heckbert, T. (2000). The death of a pet: Implications for loss and bereavement across the lifespan [Electronic version]. *Journal of Personal and Interpersonal Loss, 5,* 361–395.

Ramesh, R. (2010, 9 December). Disabled people 'twice as likely' to miss out on careers, courses and holidays. *Guardian Unlimited.* http://www.guardian.co.uk/society/2010/dec/09/disabled-people-missing-out-jobs-courses Accessed 20 May 2012.

Rijken, M. & van Beek, S. (2011). About cats and dogs...Reconsidering the relationship between pet ownership and health related outcomes in community-dwelling elderly [Electronic version]. *Social Indicators Research, 102*, 373–388.

Risley-Curtiss, C. (2010). Social work practitioners and the human-companion animal bond: A national study [Electronic version]. *Social Work, 55(1)*, 38–46.

Risley-Curtiss, C., Holley, L.C. & Wolf, S. (2006). The animal-human bond and ethnic diversity [Electronic version]. *Social Work, 51(3)*, 257–268.

Roberts, G. & Wolfson, P. (2004). The rediscovery of recovery: open to all [Electronic version]. *Advances in Psychiatric Treatment, 10*, 37–49.

Rollnick S., & Miller, W.R. (1995). What is motivational interviewing? [Electronic version]. *Behavioural and Cognitive Psychotherapy, 23,* 325–334.

Sachs-Ericsson, N., Hansen, N.K. & Fitzgerald, S. (2002). Benefits of assistance dogs: A review [Electronic version]. *Rehabilitation Psychology, 47(3)*, 251–277.

Serpell, J.A. (1991). Beneficial aspects of pet ownership: Some aspects of human health and behaviour. *Journal of the Royal Society of Medicine, 84*, 717–720.

Serpell, J.A. (Ed.) (1995). *The Domestic Dog: Its evolution, behaviour and interactions with people.* Cambridge: Cambridge University Press.

Serpell, J.A. (2008). *In the company of animals: A study of human-animal relationships.* Cambridge: Cambridge University Press.

Siegal, J. (1990). Stressful life events and use of physician services among the elderly: The moderating role of pet ownership [Electronic version]. *Journal of Personality and Social Psychology, 58(6),* 1081–1086.

Sharkin, B.S. & Knox, D. (2003). Pet loss: Implications for the psychologist [Electronic version]. *Professional Psychology: Research and Practice, 34(4),* 414–421.

Slade, M. (2009). *Personal recovery and mental illness: A guide for mental health professionals.* Cambridge: Cambridge University Press.

Strauss, A.L. & Corbin, J. (1998). *Basics of qualitative research: Grounded theory procedures and techniques (2nd Ed.).* Thousand Oaks, CA: Sage.

Taylor. A. (2009). *Physical activity and mental health.* Royal College of Psychiatrists. Accessed 20 May 2012.

http://www.rcpsych.ac.uk/mentalhealthinfo/treatments/exerciseandmentalhealth.aspx

Tweed, A. & Charmaz, K. (2011) Grounded theory methods for mental health practitioners. In D. Harper and A. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners.* Chichester, UK: John Wiley & Sons, Ltd.

Valentine, D.P., Kiddoo, M. & LaFleur, B. (1993). Psychosocial implications of service dog ownership for people who have mobility or hearing impairments. *Social Work in Health Care, 19*, 109–125.

Vormbrock, J.K. & Grossberg, J.M. (1988). Cardiovascular effects of human-pet dog interactions [Electronic version]. *Journal of Behavioural Medicine, 11*, 509–517.

Walsh, F. (2009a). Human-animal bonds I: The relational significance of companion animals [Electronic version]. *Family Process, 48(4)*, 462–480.

Walsh, F. (2009b). Human-animal bonds II: The role of pets in family systems and family therapy [Electronic version]. *Family Process, 48(4)*, 481–499.

Walsh, P.G., Mertin, P.G., Verlander, D.F. & Pollard, C.F. (1995). The effects of a 'pets as therapy' dog on persons with dementia in a psychiatric ward [Electronic version]. *Australian Occupational Therapy Journal, 42*, 161–166.

Wells, D.L. (2004). The facilitation of social interactions by domestic dogs. *Anthrozoös, 17*, 340–352.

Wells, D.L. (2009). The effects of animals on human health and wellbeing [Electronic version]. *Journal of Social Issues, 65(3)*, 523–543.

Wells, D.L. (2011). The value of pets for human health. *The Psychologist, 24(3)*, 172–176.

Willig, C. (2008). *Introducing qualitative research in psychology*. New York: Open University Press.

Winnicott, D.W. (1971). *Playing and reality*. London: Tavistock Publications.

Wisdom, J.P., Saedi, G.A. & Green, C.A. (2009). Another breed of "service" animals: STARS study findings about pet ownership and recovery from serious mental illness [Electronic version]. *American Journal of Orthopsychiatry, 79(3)*, 430–436.

Wood, L.J., Giles-Corti, B., Bulsara, M.K. & Bosch, D.A. (2007). More than a furry companion: The ripple effect of companion animals on neighbourhood interactions and sense of community [Electronic version]. *Society and Animals, 15*, 43–56.

Wolfson, P., Holloway, F. & Killaspy, H. (Eds.) (2009). *Enabling recovery for people with complex mental health needs: A template for recovery services* [Electronic version]. London: Royal College of Psychiatrists: Faculty of Rehabilitation and Social Psychiatry.

Wright, J.C. & Moore, D. (1982). Animal companions and one-year survival of patients after discharge [Electronic version]. *Public Health Reports, 97(4)*, 380–381.

Yardley, L. (2000). Dilemmas in qualitative health research [Electronic version]. *Psychology and Health, 15*, 215–228.

Zissleman, M.H. Rovner, B.W., Shmuely, Y. & Ferrie, P. (1996). A pet therapy intervention with geriatric psychiatry inpatients [Electronic version]. *American Journal of Occupational Therapy, 50(1)*, 47–51.

Zimolag, U. & Krupa, T. (2009). Pet ownership as a meaningful community occupation for people with serious mental illness [Electronic version]. *American Journal of Occupational Therapy, 63(2)*, 126–137.

Appendices

Appendix 1 – University of Surrey Faculty of Arts and Human Sciences Ethics Committee: Ethical approval

UNIVERSITY OF SURREY

Dr Vicky Senior (Deputy Chair)
Faculty of Arts and Human Sciences Ethics Committee
University of Surrey

Faculty of
Arts and Human Sciences

Faculty Office
AD Building
Guildford, Surrey GU2 7XH UK

T: +44 (0)1483 689445
F: +44 (0)1483 689550

www.surrey.ac.uk

Vicki Woolcock
PsychD Clinical Trainee
Department of Psychology
University of Surrey

18th January 2011

Dear Vicki

Reference: 549-PSY-10 (with conditions)
Title of Project: Improving understanding of the role of companion animals in recovery from mental health difficulties: the views of service users

Thank you for your submission of the above proposal.

I am pleased to advise that this proposal has received a favourable ethical opinion from the Faculty of Arts and Human Sciences Ethics Committee provided that the following conditions are adhered to:

1. Details regarding the safe and secure storage of the data should be included in the information sheet.
2. Please mention in the protocol where the interviews will take place (i.e. the location of the support group) – this information currently only seems to be in the risk assessment.
3. Please ensure that recruitment process does not involve any coercion (last bullet of the methods and in the flow chart). The appropriate process is that potential participants can have the study explained to them by the group facilitator and given an information sheet, but should volunteer their willingness to participate direct to the researcher, who can then arrange the interview time etc.
4. Please provide a copy of the information sheet for the support groups/facilitators to the Ethics Committee for approval.
5. Please submit a copy of the debrief sheet that will be used with participants.
6. Please make clearer in the information sheet for participants that risk issues relate also to animal welfare.

If there are any significant changes to this proposal you may need to consider requesting scrutiny by the Faculty Ethics Committee.

Yours sincerely

Dr Vicky Senior
Deputy Chair

Faculty of Arts and Human Sciences
Ethics Committee

Chair's Action

Ref:	**549-PSY-10 (with conditions)**
Name of Student:	**VICKI WOOLCOCK**
Title of Project:	**Improving understanding of the role of companion animals in recovery from mental health difficulties: the views of service users**
Supervisor:	**PROFESSOR ARLENE VETERE**
Date of submission:	**15TH DECEMBER 2010**
Date of re-submission:	

The above Project has been submitted to the FAHS Ethics Committee.

Favourable ethical approval has now been granted.

Signed: _____
Dr Vicky Senior
Deputy Chair

Dated: 18/01/11

Appendix 2 – Research participant and support group facilitator information sheets and participant debrief sheet

UNIVERSITY OF SURREY

Information about this research project

You are being invited to participate in a Doctorate of Clinical Psychology research study. Please take the time to read this information sheet and please feel free to ask the researcher if you have any questions at all.

Why are we doing this research?

With one in four people likely to experience mental health difficulties over the course of their lifetime, the impact on individuals, families and society is considerable. We are interested in how people who have experienced mental health difficulties may manage their own recovery process, and in particular whether being a 'pet owner' has any impact on mental well-being.

What will be involved?

Your support group leader or another member of charity staff has asked if you may be interested in taking part as they are aware that you are living (or have recently lived) with a dog or cat. Taking part will involve being interviewed by a researcher, who is a trainee clinical psychologist and will ask some questions about your experiences of mental health difficulties and having a companion animal. It is important to remember that there are no right or wrong answers; it is your experience that matters. Each interview is anticipated to be around an hour long, although this is flexible and you can stop the interview at any point without giving a reason. Each interview will be recorded using a digital recorder to enable the researcher to type out your responses. If you would prefer to have someone with you during the interview, your support worker can sit in, although we will not ask them to answer any questions. We understand that discussing such personal issues can sometimes cause people to feel distressed and so following the interview there will be an opportunity to talk through any difficult feelings that may have arisen with a member of charity staff.

Do I have to take part?

It is completely your decision as to whether or not you wish to take part in this study. If you would like to take part, you will be given this information sheet to keep and asked to sign a consent form. You are free to withdraw from the research at any time, without giving a reason, until the end of data collection (anticipated to be December 2011). Unfortunately it is no longer possible withdraw following this as the data will be pooled together for analysis. If you decide you do not wish to participate or that you would like to withdraw this will not affect you or the services you receive in any way.

Confidentiality

All data will be anonymised and held securely (in password protected files/locked cabinet for paper) in accordance with the data protection act. It will not be possible to identify your responses; however any risk issues (including animal welfare concerns) will be shared as necessary to prevent harm arising to you or others.

UNIVERSITY OF SURREY

Support workers: Information about this research project

Thank you for agreeing to assist in the recruitment of participants for this Doctorate of Clinical Psychology research study. Please take the time to read this information sheet and please feel free to ask the researcher if you have any questions at all.

Why are we doing this research?

With one in four people likely to experience mental health difficulties over the course of their lifetime, the impact on individuals, families and society is considerable. We are interested in how people who have experienced mental health difficulties may manage their own recovery process, and in particular whether being a 'pet owner' has any impact on mental well-being.

Who can take part in the research?

We are looking for participants who are working age adults who have previously experienced serious mental illness, for which they have sought treatment from Mental Health Services (including relevant charities). It is important that service users should feel that they are at (or have some experience of) a 'recovery' stage in managing their mental health difficulties. Participants should be 'pet owners' themselves or should have owned / lived with a companion animal (a dog or cat) in the last two years. They should also have English language skills at a level equivalent to a native speaker, to ensure they are able to understand the process of consenting to participate in the research. The main reason it may not be appropriate for a service user to participate, is if they feel unduly distressed as a result of their mental health difficulties at the time of requesting to take part in the project. Additionally potential participants should not be deemed to have a diagnosis of learning difficulties or other significant cognitive impairment.

What will be involved?

For service users, taking part will involve being interviewed by a researcher, who is a trainee clinical psychologist and who will ask them some questions about their experiences of mental health difficulties and having a companion animal. Each interview is anticipated to be around an hour long, although this is flexible and service users can stop the interview at any point without giving a reason. Each interview will be digitally recorded to enable service users' responses to be typed up. If they would prefer to have someone with them during the interview, you can sit in,

although we will not ask you to answer any questions. We understand that discussing such personal issues can sometimes cause people to feel distressed and so we ask that there will be an opportunity for service users who have taken part to talk through any difficult feelings they may have following the interview, with charity staff.

Do service users have to take part?

Any decision as to whether a service user wishes to take part in this study should be completely voluntary. They are free to withdraw from the research at any time, without giving a reason, until the end of data collection (anticipated to be September 2011). Unfortunately it is no longer possible withdraw following this as the data will be pooled together for analysis. If they decide not to participate or that they would like to withdraw at any point it is important to stress that this will not affect them or the services they receive in any way.

Confidentiality

All data will be anonymised and stored securely in password protected files (electronic data) or in a locked cabinet for any hardcopies of data . It will not be possible to identify individual service user's responses from the data; however any risk issues (including issues of animal welfare) will be shared as necessary to prevent harm arising to the service user themselves or others.

How can I get further information or assist a service user to participate?

For more information or to assist a service user to gain further information or take part, please feel free to contact Vicki Woolcock, Trainee Clinical Psychologist via email: v.woolcock@surrey.ac.uk

What should I do if the service user or I wish to discuss any issues or concerns we may have about the research?

Any complaints or concerns about any aspect of the way this research project is being carried out will be addressed; in the event of any difficulties arising please contact the research supervisor, Prof. Arlene Vetere on (01483) 68 2911

UNIVERSITY OF SURREY

Thank you for taking part in this research

Your contribution to this study is extremely valuable and your responses will help us to understand how dog and cat ownership may play a role in recovery from severe mental health difficulties. The recovery movement highlights service users' self-management of their distress as a foundation of successful personal recovery. However existing research appears to have largely ignored service users' perceptions of how and why animals may have been influential in their recovery. Therefore this research aims to address this important but previously under-represented area. Several explanations for the role of 'pet ownership' in recovery have been proposed so far, however none of these provide the 'whole answer'. For example it has been suggested that animals have an ability to alter how an individual feels by redirecting their focus, and accordingly as emotions are known to direct behaviour, interaction with animals could cause a person to respond differently to a situation. Other explanations include the function animals perform: in promoting social interaction, in empowering an individual to regain or maintain a purposeful life through responsibility for others and in alleviating the physiological effects of stress on the body.

Please remember that you are free to withdraw from the research at any time, without giving a reason, until the end of data collection (anticipated to be September 2011). If, for whatever reason, you later decide that you no longer want your responses to be part of this study, then please contact Vicki Woolcock (see details below) to have your data removed from the study and destroyed. Please be assured that if you decide you would like to withdraw this will not affect you or the services you receive in any way.

I would like to take this opportunity to thank you again for participating and helping with this study. However, please do not show this debriefing sheet or discuss any aspect of the study with other service users. In order for us to talk to people about their own experiences, it is important that future participants do not have any particular expectations about the questions we are asking. Thanks!

Finally, if you would like more information, or have any further questions about any aspect of this study, then please feel free to contact **Vicki Woolcock, Trainee Clinical Psychologist**: v.woolcock@surrey.ac.uk. Any complaints or concerns about any aspect of the way this research project is being carried out will be addressed, therefore in the event of any difficulties arising please contact the research supervisor, Prof. Arlene Vetere on (01483) 68 2911.

Appendix 3 – Informed consent form for participants

UNIVERSITY OF SURREY

Consent form for participants

Major Research Project title:

Improving understanding of the role of dog and cat ownership in recovery from severe mental health difficulties; the views of service users.

Supervisor Prof. Arlene Vetere

Researcher Vicki Woolcock
Signed:
Date:

Name of volunteer
Signed:
Date

	Please tick box
1. I confirm that I have read and understood the information sheet dated [ ] for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time until December 2011 without giving any reason, and that neither I nor the service I receive will be affected in any way.	☐
3. I understand that, under the Data Protection Act, I can at any time (until December 2011) ask for access to the information I have provided and that I can also request for any information I have provided to be destroyed if I so wish.	☐
4. I understand that any complaint or concern about any aspect of the way I have been dealt with during this research will be addressed; in the event of any difficulties arising please contact Prof. Arlene Vetere on (01483) 68 2911	☐
5. I agree to take part in the above study.	☐

Appendix 4 – Interview schedule including revisions

N.B. Revisions shown in colour: amendments: Blue = post interview 5, Red = post interview 8

1. To begin with, it would be really helpful to understand some of your experiences of owning companion animals. Would you be able to tell me a bit about your most recent 'pet dog or pet cat'?
2. So thinking about yourself as a 'dog or cat owner', how has this role co-existed with some of the mental health difficulties you may have experienced?
3. How would you describe your relationship with your dog or cat?
   Some people have said that they consider their dog or cat to be part of the family, and I just wondered if you have any thoughts on that.
4. How would you define or describe your recovery from mental health difficulties?
5. What role, if any, do you believe your dog or cat has played in your recovery?
6. At times of stress or difficulties related to your mental health, who offers you support?
   ~~At times of stress or difficulties related to your mental health, who offers you support?~~
   Some people have suggested that their pet increases their ability to cope with difficult situations and I'm wondering if this is something you have experienced, and if so, why you think this might be?
7. What impact, if any, do you believe your mental health difficulties may have had on your dog or cat? Please think about both benefits and challenges in answering this question.
8. Thank you for your help in answering the questions so far. I'm just wondering if there's anything else you feel is relevant that we haven't yet talked about.

Appendix 5 – Samples of coding

Interview 2 – Andrew (owns dogs and cats)

Focused coding	Initial coding	Data	Memos
Being able to tell when animals aren't well, associated "downside" of vets On a low income, unexpected vet fees are a "financial hazard" Making difficult decisions about whether to treat or "let them go", then cutting back to get them treatment they need	when they're not themselves you know, downside being obviously you've got to take them to the vets and you've got vet fees. when I was working it wasn't a problem, but obviously when you're on a low budget income a financial hazard, because they're just unexpected you know. do you keep them or do you, and you don't want to let them go so you're sitting there, having to cut back and scrape the bottom of the barrel.	On the whole it.....One of the things it makes you aware of them, so when they're not themselves you know, and the downside being obviously you've got to take them to the vets and you've got vet fees and all that sort of stuff. In my position, when I was working it wasn't a problem, but obviously when you're on a low budget income, it does become a financial hazard, because they're just unexpected you know. That's absolutely right I think. That's where the issues become, do you keep them or do you, and you don't want to let them go so you're sitting there, having to cut back and scrape the bottom of the barrel to make sure they're looked after sort of thing.	Again the financial responsibilities of owning a pet have come up relatively quickly in the interview. I can empathise with this dilemma, vet fees can be prohibitively expensive but when you're faced with the choice of losing a pet or paying for treatment, it doesn't really seem much of a choice.

Appendix 6 – Axial coding and category development

The following questions were considered in taking focused codes forward, via clustering, in order to generate categories (Strauss & Corbin, 1998):

1) conditions, the context in which the category operates (see 'caveats')

2) actions/interactions, how participants respond within a situation

3) consequences, the results of actions taken by a participant.

Therefore the focused codes: affection, unconditional acceptance and physical contact (e.g. stroking) were clustered together to construct the sub-category: comfort. Whilst the subcategories: comfort, communication and company were further clustered to form the larger category: relating.

Appendix 7 – Memo writing

Memo: 22/01/12

Title: what is it about social interaction?

I was spending time coding an interview I did with 'Alison & Remy' before Christmas & a phrase leapt off the page:

"Remy has helped really because when you go for a walk it's like having a baby, lots of people talk to you, especially if they've got a dog, they'll stop & talk".

This really resonated as people do often stop & talk, I find even if they don't have a dog. It is like having a baby in that people ask the same questions: is it a boy/girl?, how old is he/she? & they also want to tell you about their experiences of dog ownership, for example "I had a Labrador that colour" "they're such lovely dogs" etc., this got me thinking about a paper by Archer regarding the evolutionary reason (one which I remember from undergrad) that people love pets – that their infantile features (large prominent eyes, 'cuddliness', dependence) somehow invoke a primitive response that connives us (like babies) to look after them & keep them safe. This got me thinking about attachment theory (and how it is that babies are pre-programmed to be "attractive" they even smell nice – this has been reported in new

scientist & they behave in way that encourages people to like them & want to interact with them from a very young age (even a few days old — recognising primary care-giver, reciprocal social smiling), Pets, dogs in particular, do this too — they can make it evident that they like a person, (through body language — ~~tattered~~ body/tail carriage, loose wagging tail), also through behaviour, following or tracking an owner's movements around the house, fetching toys to encourage interacting & play with owner.

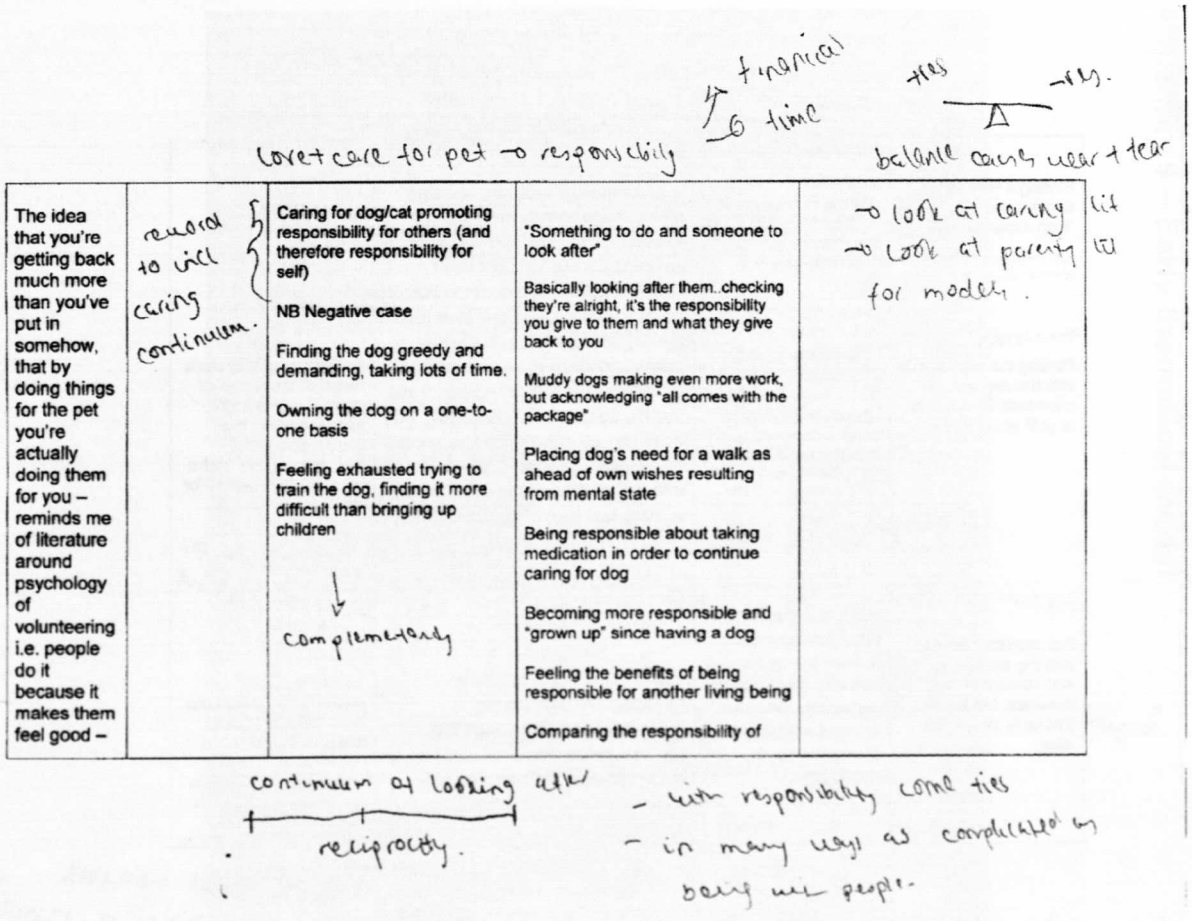
This also made me wonder - this perceived (& actual - in some respects) similarity between pets & babies about "spoilt" pets. This fascinates me as, like children, one person's idea of 'normal' treatment (ie giving a pet a birthday present) might mean spoiling the pet to another person - especially if the pet has a 'working' function eg. as a guard dog or 'mouser'. However the pet retail/accessories market has expanded exponentially in recent years, which I think reflects how many more people are considering their pets as part of the family.

Appendix 8 – Examples of coding following discussion:

i) with research supervisor

ii) with grounded theory S.I.G. (peer researchers)

(n.b. peer researcher's comments in pencil with my subsequent amendments to coding shown in pen)



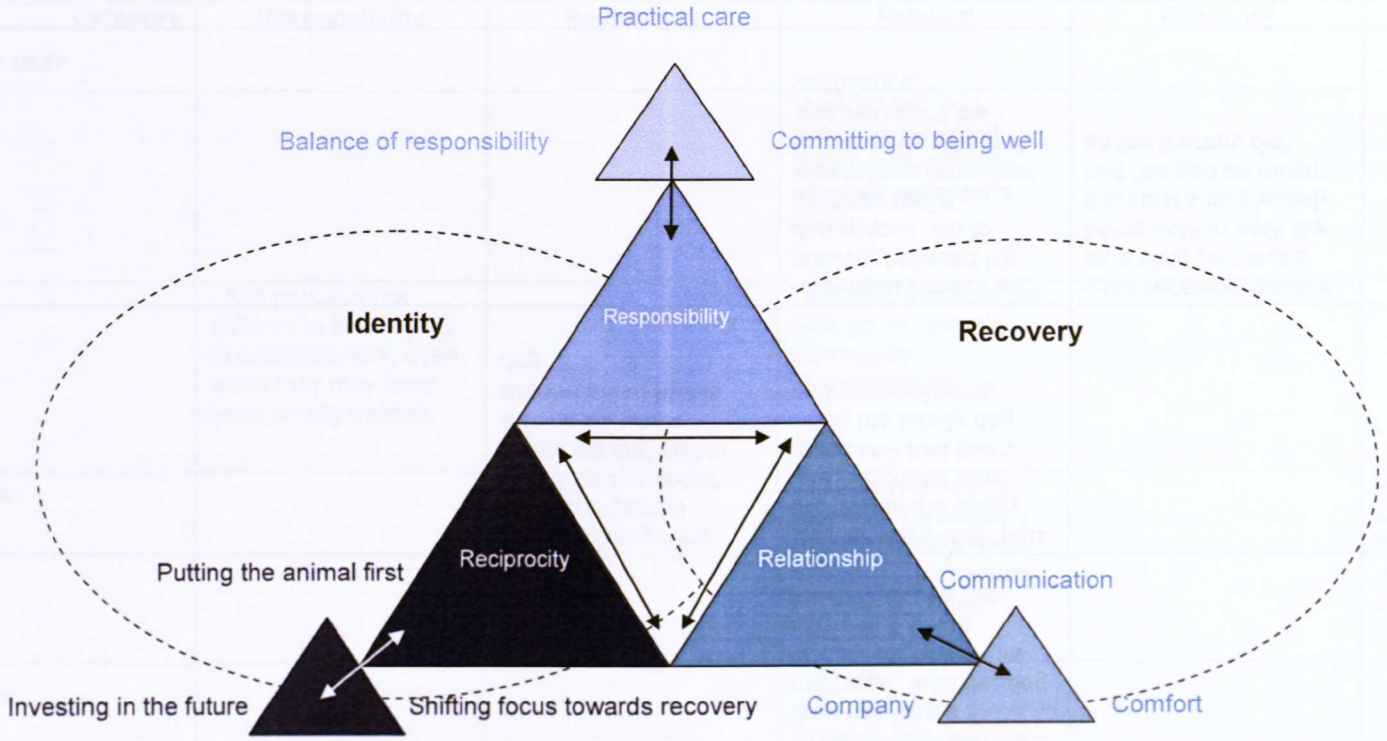
The idea that you're getting back much more than you've put in somehow, that by doing things for the pet you're actually doing them for you – reminds me of literature around psychology of volunteering i.e. people do it because it makes them feel good –	record to incl caring continuum.	**Caring for dog/cat promoting responsibility for others (and therefore responsibility for self)** **NB Negative case** Finding the dog greedy and demanding, taking lots of time. Owning the dog on a one-to-one basis Feeling exhausted trying to train the dog, finding it more difficult than bringing up children ↓ complementary	"Something to do and someone to look after" Basically looking after them..checking they're alright, it's the responsibility you give to them and what they give back to you Muddy dogs making even more work, but acknowledging "all comes with the package" Placing dog's need for a walk as ahead of own wishes resulting from mental state Being responsible about taking medication in order to continue caring for dog Becoming more responsible and "grown up" since having a dog Feeling the benefits of being responsible for another living being Comparing the responsibility of	→ look at caring (it → look at parenty (li for models.

Finding it hard to tire dog out and meet dog's "high expectations" at mercy of dogs demands thinking perceiving ~~Feeling~~ the relationship with the dog is a mismatch, feeling a lot of guilt about that Dog deserving of better/ more Not providing the dog with the excitement and stimulation he deserves, but ~~feeling~~ that he is well looked after anxiety	he has huge energy and high expectations I think and you come in tired and it's like "oh right what happens now?" Constant demands dog in control? I think we're slightly mismatched, he would be a fantastic dog for a big family with lots of things happening and I actually feel a lot of guilt about that You know, that I'm not really providing him with um the excitement and stimulation that perhaps he deserves, or might want, but um anyway he's well looked after.	So some things like that, and also he has huge energy and high expectations I think and you come in tired and it's like "oh right what happens now?", you come in from 2 hours of dog walking and then feed the dog and then "for goodness sake go to sleep or something!" and it's like "no I've still got energy, I still want to do stuff". In fact I think we're slightly mismatched, he would be a fantastic dog for a big family with lots of things happening and I actually feel a lot of guilt about that. Ok You know, that I'm not really providing him with um the excitement and stimulation that perhaps he deserves, or might want, but um anyway he's well looked after.	personifying dog I'm interested that she's aware of the apparent mismatch as it had occurred to me too, there's also a real feeling that she's "not a good enough owner" for the dog. ie. is he a fantastic dog for someone else but not her. This seems a bit contradictory in that she feels she's not giving him what he deserves but actually "he's well looked after" – I believe her when she says this too.

does this make her feel better or is she doing it reassure me? 6

Appendix 9 – Early theoretical model

Appendix 10 – Diagram showing the grounded theory of the role of companion animals in their owners' recovery from mental health difficulties



Appendix 10 – The grounded theory of the role of companion animals in their owners' recovery from mental health difficulties

Appendix 11 – Examples of themes from the service user focus group for validation (organised by category)

n.b all service user's names have been changed to protect anonymity

Category Service user	Responsibility	Reciprocity	Relating	Recovery	Identity
Terrence			-Relationship with his dog was "like a marriage", with the dog waiting for him to get home and being pleased to see him.		
Theresa		-Noticed her young grandson gained confidence in social situations and status with peers when accompanied by his dog.	-Felt strongly that "pets are part of the family" and described how upset she had been when the family dog had gone missing.		
Tony			-Identified himself as autistic, believed his dog helped him to manage social interactions "she went everywhere with me", and increased his confidence.	-Had received therapy as a child and found being able to walk the therapist's dog weekly had "helped as much as the therapy did".	

Category Service user	Responsibility	Reciprocity	Relating	Recovery	Identity
Karen			-Noticed her dog behaving differently (being very gentle) after her daughter's surgery.		
Alan	- Felt pets are like children in their loyalty to adults/owners, even when they may have been cruelly treated.		-Believed that cats can take on an owner's personality characteristics.		
Margot			-Raised Winnicott's theory of transition objects linked to pets enabling their owners to manage difficult situations.		-Felt the group had lost some of its identity as there were no longer any dogs who attended with their owners.

Appendix 12 - Implications from existing literature

Previous work on human-animal interaction also suggests practical implications mental health services should consider and five of these are summarised as follows:

1. Mental health professionals across different disciplines (i.e. social workers, psychologists) need a greater awareness of research demonstrating the impact of companion animals on wellbeing as there is a current lack of emphasis on human-animal interaction in the content of many professional training courses (Risley-Curtiss, 2010).
2. Mental health professionals do not typically ask about companion animals as standard practice during initial assessments (e.g. Risley-Curtiss, 2010). Therefore including pets on family genograms would open up discussion about their role in the family system (Walsh, 2009b).
3. Mental health services should consider whether they can offer practical support to service users with pets e.g. in accessing relevant financial benefits or appropriate accommodation (Netting *et al.*, 1987), helping service users to access subsidised vet care (such as that provided by charities) or in developing budgeting skills (Risley-Curtiss, 2010).
4. Pet owners can experience disenfranchised grief as they believe others do not understand their grief following the loss of a pet (e.g. Morley & Fook, 2005), therefore where necessary mental health professionals should offer appropriate services e.g. grief counselling.
5. Both statutory services and charities need to promote a co-ordinated strategy for workers in domestic violence services, children's services, animal rescue centres and veterinarians, as the links between acts of violence against animals and associated risks for vulnerable people becoming victims of violence are well established (e.g. Ascione & Shapiro, 2009).

Research Log

1	Formulating and testing hypotheses and research questions	X
2	Carrying out a structured literature search using information technology and literature search tools	X
3	Critically reviewing relevant literature and evaluating research methods	X
4	Formulating specific research questions	X
5	Writing brief research proposals	X
6	Writing detailed research proposals/protocols	X
7	Considering issues related to ethical practice in research, including issues of diversity, and structuring plans accordingly	X
8	Obtaining approval from a research ethics committee	X
9	Obtaining appropriate supervision for research	X
10	Obtaining appropriate collaboration for research	X
11	Collecting data from research participants	X
12	Choosing appropriate design for research questions	X
13	Writing patient information and consent forms	X
14	Devising and administering questionnaires	
15	Negotiating access to study participants in applied NHS settings	
16	Setting up a data file	
17	Conducting statistical data analysis using SPSS	X
18	Choosing appropriate statistical analyses	X
19	Preparing quantitative data for analysis	X
20	Choosing appropriate quantitative data analysis	X
21	Summarising results in figures and tables	X
22	Conducting semi-structured interviews	X
23	Transcribing and analysing interview data using qualitative methods	X
24	Choosing appropriate qualitative analyses	X
25	Interpreting results from quantitative and qualitative data analysis	X
26	Presenting research findings in a variety of contexts	X
27	Producing a written report on a research project	X
28	Defending own research decisions and analyses	X
29	Submitting research reports for publication in peer-reviewed journals or edited book	
30	Applying research findings to clinical practice	X

URN 6111384

Qualitative Research Project – Abstract

An interpretative phenomenological analysis: How does being a trainee clinical psychologist influence self-identity?

Year One

June 2010

Word count: 272 words

Role identity theory hypothesises that self-concept comprises the meanings individuals attach to the varied roles they inhabit. The most salient roles give the greatest sense of meaning, and contribute significantly to the definition of self-concept. Professional roles therefore significantly reflect values and behaviour and are influential in identity construction. This study asked how role identity, and consequently self-identity, changed during the formative experience of clinical psychology training. Using qualitative, interpretive phenomenological analysis enabled detailed exploration of the interviewee's view of the world and an insider's perspective. Participants were selected from a group of second year trainee clinical psychologists, with four individuals agreeing to participate in semi-structured interviews. The sample was composed of four white British women from middle-class backgrounds, with ages ranging from 26-30 years. The interview schedule included questions about: being a trainee clinical psychologist and the influence this has on self-identity, personal values and behaviour (in both private and professional life); in addition to others' perceptions of the individual that may have changed since becoming a trainee clinical psychologist. Four main themes, or areas of influence, arose during data analysis: self-awareness, core values, personal life and achievement. Consistent with the literature, we found that the pre-existing values and behaviour of our interviewees was significantly reflected in the process of training as a clinical psychologist, and was influential in their construction of identity. It was also evident that trainees' perceptions of their self-identity had developed since beginning training, with several reporting increased personal responsibility and self-awareness. To build on these findings, future research could explore the transition of clinical psychology trainees following qualification and how they make sense of this experience.